

FOR STATE
 HEALTH DEPT.

03997

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03996

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 725 Chillum Heights Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Frank Benjamin Abernathy			4. DATE OF DEATH Month Day Year 3 3 19 67		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-15-11		9. AGE (In years last birthday) yrs. 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maiden N. C.	
13. FATHER'S NAME George P. Abernathy			14. MOTHER'S MAIDEN NAME Bertha Mae Cloninger		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Geo. Abernathy 1207 Dalewood Dr. S.W. Spg.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary atelectasis 527.0 -DUE TO- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) and bronchial aspiration -DUE TO- (c) and cirrhosis of liver with fatty changes					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe M.D. EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland			22. DATE SIGNED 3-5-67		
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE THEREOF 3-6-67	23c. NAME OF CEMETERY OR CREMATORY Hickory Grove Church		23d. LOCATION (City or Town) (County) (State) Gaston N. C.
24. FUNERAL DIRECTOR Robert E. Wilhelm 4308 Suitland Rd. Suitland Md.			25a. REC'D BY REGISTRAR DATE MAR 7 1967		
			25b. REGISTRAR'S SIGNATURE Charles Judge		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03283

03283

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings and a comparison of the results with previous studies. The fourth part of the report is a conclusion and a list of references.

2. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings and a comparison of the results with previous studies. The fourth part of the report is a conclusion and a list of references.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03998

CERTIFICATE OF DEATH

03997

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beall Meade (Hyattsville)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7514 Dover Lane		d. STREET ADDRESS 4300 75th Ave.	
3. NAME OF DECEASED (Type or print) Henry		4. DATE OF DEATH Month March Day 8 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 3, 1897
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. U.S.A.		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov.	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry L. Adams, Sr/		14. MOTHER'S MAIDEN NAME Badcock	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 1	
17. INFORMANT Mary P. Adams (Same as # 2)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 446X DUE TO Arteriosclerotic renal vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6 mo. over 6 mo.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1953 , to 3-8- , 1967, that (I) (we) last saw the deceased alive on 3-8- , 1967, and that death occurred at 5:00am from causes and on the date stated above.			
22a. SIGNATURE John Kehoe, M.D.		22b. DATE SIGNED 3-8-67	
22c. PHYSICIAN'S NAME (Type) John Kehoe, M.D.		22d. ADDRESS 6300 Riverdale Rd., Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 10, 1967	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR MAR 13 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal at any event, within 72 hours after death.

2323

2002

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03999

03998

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			c. LENGTH OF STAY IN 1b DOA		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital			d. STREET ADDRESS 3108 Craiglawn Road		
3. NAME OF DECEASED (Type or print) Barry T Adkins			4. DATE OF DEATH 3 23 19 67		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-30-1951		9. AGE (In years last birthday) 15 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Minn	
13. FATHER'S NAME Arthur Adkins			14. MOTHER'S MAIDEN NAME Betty Schorey		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Arthur Adkins Address Same as 2 D	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 8124 DUE TO Compound occipital skull fracture Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple fractures of left leg DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by car.			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 9:22pm 3-23-1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 3700 block Powder Mill Rd., Beltsville, Md.	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 3-24-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 3,24.67		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory	
23d. LOCATION (City or Town) (County) (State) Washington D C		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR Lee Funeral Home 300.4th st N E		ADDRESS		DATE MAR 27 1967	

5252

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

1000

—

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04000

CERTIFICATE OF DEATH

03999

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 18 hrs.35mins		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside 16.1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1122-52nd St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George W. Ammon				4. DATE OF DEATH Month Day Year March 21, 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/8/85		9. AGE (In years lost birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Ammon				14. MOTHER'S MAIDEN NAME Annie Dant			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Emily E Payne Address Bladensburg, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Lung and Liver 1992 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) primary unknown DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 20, 1967 , to March 21, 1967 , that (I) (we) last saw the deceased alive on March 21, 1967 , and that death occurred at 5:30xx from causes and on the date stated above.							
22a. SIGNATURE Edwin J. Jensen				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. PM		22b. DATE SIGNED March 22, 1967	
22c. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M.D.				22d. ADDRESS Prince Georges General Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 24, 1967	23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg Pro Geo Md.			
24. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE MAR 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

00000

00000

Prince Georges

King's Road

Prince Georges

10 Prince Georges

10 Prince Georges

Prince Georges General Hospital

100-1000 St.

Name	White	XX	1/2/1967	March 11, 1967
Prince Georges General Hospital				
100-1000 St.				

10 Prince Georges

10 Prince Georges

March 11, 1967

2:30 PM

March 11, 1967

March 11, 1967

Prince Georges General Hospital

Prince Georges General Hospital

March 11, 1967

March 11, 1967

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04001

CERTIFICATE OF DEATH

04000

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 hr 45 mins	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant		d. STREET ADDRESS 829 Booker Place	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Archie		4. DATE OF DEATH Month Day Year March 9, 19 67	
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9, 1967
9. AGE (In years last birthday) yrs. 1		10. IF UNDER 1 YEAR Months Days Hours Min. 1 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Pr. Geo. Co., Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Michael L. Archie		14. MOTHER'S MAIDEN NAME Jacquelyn Elizabeth Taylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Jacquelyn Elizabeth Taylor		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Natural Atelectasis DUE TO 7625 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) prematurity 600 gms. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 9, 1967 , to March 9, 1967 , that (I) (we) last saw the deceased alive on March 9, 1967 , and that death occurred at 10:40 , from causes and on the date stated above.			
22a. SIGNATURE Albert I. Robins		22b. DATE SIGNED 3/10/67	
22c. PHYSICIAN'S NAME (Type) Albert I. Robins, M.D.		22d. ADDRESS 1330 New Hampshire Ave. NW, Wash. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 3/18/67	
23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp		23d. LOCATION (City or Town) (County) (State) Cheverly PG Maryland	
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE MAR 21 1967	

00040

RECORD OF SERVICE

70020

1. NAME: [illegible]
2. DATE OF BIRTH: [illegible]
3. PLACE OF BIRTH: [illegible]
4. SEX: [illegible]
5. RACE: [illegible]
6. RELIGION: [illegible]
7. OCCUPATION: [illegible]
8. EDUCATION: [illegible]
9. MARITAL STATUS: [illegible]
10. SOCIAL SECURITY NUMBER: [illegible]
11. CURRENT ADDRESS: [illegible]
12. PREVIOUS ADDRESSES: [illegible]
13. EMPLOYMENT HISTORY: [illegible]
14. MILITARY SERVICE: [illegible]
15. CRIMINAL RECORD: [illegible]
16. PSYCHIATRIC HISTORY: [illegible]
17. PHYSICAL EXAMINATION: [illegible]
18. MENTAL EXAMINATION: [illegible]
19. TREATMENT HISTORY: [illegible]
20. CURRENT TREATMENT: [illegible]

1. NAME: [illegible] 2. DATE OF BIRTH: [illegible] 3. PLACE OF BIRTH: [illegible] 4. SEX: [illegible] 5. RACE: [illegible] 6. RELIGION: [illegible] 7. OCCUPATION: [illegible] 8. EDUCATION: [illegible] 9. MARITAL STATUS: [illegible] 10. SOCIAL SECURITY NUMBER: [illegible] 11. CURRENT ADDRESS: [illegible] 12. PREVIOUS ADDRESSES: [illegible] 13. EMPLOYMENT HISTORY: [illegible] 14. MILITARY SERVICE: [illegible] 15. CRIMINAL RECORD: [illegible] 16. PSYCHIATRIC HISTORY: [illegible] 17. PHYSICAL EXAMINATION: [illegible] 18. MENTAL EXAMINATION: [illegible] 19. TREATMENT HISTORY: [illegible] 20. CURRENT TREATMENT: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

74

3

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04002

CERTIFICATE OF DEATH

04001

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 8217 Quentin Street	
3. NAME OF DECEASED (Type or print) First Sarah Middle E Last Aukerman		4. DATE OF DEATH Month March Day 21 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 June 1885
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Coleman		14. MOTHER'S MAIDEN NAME Mary Campbell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 194 26 1779	
17. INFORMANT Emma Jane Mc Quown		Address New Carrollton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular hemorrhage 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO DUE TO DUE TO			INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8-20-67 to 8-21-67 , that (I) (we) last saw the deceased alive on 8-20-67 , and that death occurred at 8:50 PM from causes and on the date stated above.			
22a. SIGNATURE John Kehoe M.D.		22b. DATE SIGNED 3-22-67	
22c. PHYSICIAN'S NAME (Type) Dr. John Kehoe, M.D.		22d. ADDRESS Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Mar 23, 1967	23c. NAME OF CEMETERY OR CREMATORY United Brethern Cemetary	23d. LOCATION (City or Town) (County) (State) Lycippus Pa
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR DATE MAR 28 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

10001

MINISTRY OF HEALTH

10001

Princess George

Princess George

Princess George

New Carlisle

I day

George

3211 Goulton Street

Princess George General Hospital

21

March

Amsterdam

E

21

21 June 1965

White

Female

Amsterdam

Amsterdam

Amsterdam

Amsterdam

Amsterdam

21

Amsterdam

Amsterdam

Amsterdam

Amsterdam

Amsterdam

Amsterdam

MAR 21 1965

Amsterdam

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04003

CERTIFICATE OF DEATH

04002

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3137 75th Avenue				d. STREET ADDRESS 3137 75th Avenue			
3. NAME OF DECEASED (Type or print) VICTOR COLLINS BALDERSON				4. DATE OF DEATH March 11 1967			
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar 23 1914	
				9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic				10b. KIND OF BUSINESS OR INDUSTRY Oil Heaters		11. BIRTHPLACE (County & State, or foreign country) Virginia	
13. FATHER'S NAME Blake Balderson				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 578-07-7536		17. INFORMANT Address MRS EVA L. BALDERSON Wife (2d)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 161X IMMEDIATE CAUSE (a) Carcinoma of Larynx Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CARCINOMA LARYNX (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from art , 19 66 , to 3-11 , 19 67 , that (I) (we) last saw the deceased alive on 3-11 19 67 and that death occurred at 5:00 M, from causes and on the date stated above.							
22a. SIGNATURE Leonard Hays				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-11-67	
22c. PHYSICIAN'S NAME (Type) LEONARD HAYS				22d. ADDRESS 5201 Blake Cr Hyattsville, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar 15, 1967		23c. NAME OF CEMETERY OR CREMATORY Rappahannoch Ch Cem Newland		23d. LOCATION (City or Town) (County) (State) Va	
24. FUNERAL DIRECTOR Lee Funeral Hone, 300 4th St NE, Wash.				25a. REC'D BY REGISTRAR MAR 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04003

CERTIFICATE OF DEATH

04003

1. Name of deceased: [illegible]
2. Date of death: [illegible]
3. Place of death: [illegible]
4. Cause of death: [illegible]
5. Age at death: [illegible]
6. Sex: [illegible]
7. Race: [illegible]
8. Marital status: [illegible]
9. Occupation: [illegible]
10. Signature of physician: [illegible]
11. Signature of registrar: [illegible]
12. Date of registration: [illegible]

13. Name of informant: [illegible]
14. Address of informant: [illegible]
15. Signature of informant: [illegible]
16. Date of completion: [illegible]
17. Registrar's office: [illegible]
18. County: [illegible]
19. State: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04004

CERTIFICATE OF DEATH

04003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dist Hgts</u>	
c. LENGTH OF STAY IN lb <u>10 days</u>		d. STREET ADDRESS <u>7502 Gateway Blvd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Regent Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>IRENE PEARL Irene Bass</u>		4. DATE OF DEATH Month <u>3</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/6/1911</u>
9. AGE (In years last birthday) <u>55</u> Yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Land Lord</u>		12. KIND OF BUSINESS OR INDUSTRY <u>ILL</u>	
13. FATHER'S NAME <u>Charles W. Griesemer</u>		14. MOTHER'S MAIDEN NAME <u>Olie McDurman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Marie Ebert</u>		Address <u>209 W. Park St Champaign Ill.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> <u>1810</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dehydration & Transition</u> DUE TO (c) <u>Carcinoma of bladder & Widespread metastasis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Draining Fistula from Bladder & Bowel obstruction</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I for Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 67</u> to <u>March 14, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 12, 1967</u> and that death occurred at <u>4:05 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Relvin L Minchin</u>		22b. DATE SIGNED <u>3/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RELVIN L MINCHIN</u>		22d. ADDRESS <u>6600 MARLBORO PIKE SE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-18-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calumet Park Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Crown Point Indiana</u>
24. FUNERAL DIRECTOR <u>Robert E. Wilhelm Funeral Home</u> <u>4308 Suitland Road Suitland Maryland</u>		25. REC'D BY REGISTRAR <u>MAR 20 1967</u>	
25a. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

6030

10320

152

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. John Kehoe, Deputy Med. Exam., Notified and released.

jwb

VR A15 (4)
20M 1/65

BP

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04005					04004				
1. PLACE OF DEATH a. COUNTY Pr. Geo.					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) College Park			c. LENGTH OF STAY IN 1b 3 Yrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) College Park				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9004 St. Andrews Place					d. STREET ADDRESS 9004 St. Andrews Place				
3. NAME OF DECEASED (Type or print) Katharine Kaes Beckwith					4. DATE OF DEATH Mar. 3 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 24 May 1893		9. AGE (In years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress				10b. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Kaes					14. MOTHER'S MAIDEN NAME Helena Gohres				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 577 10 8953A		17. INFORMANT Theodore R. Beckwith		Address Same as # 2		
18. CAUSE OF DEATH [Enter only one cause or line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Congestive Heart Failure</i> 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Ischemic Cardio-vascular disease</i> DUE TO (c) <i>Diabetes Mellitus</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>1950</i> to <i>FEB 67</i> , that (I) (we) last saw the deceased alive on <i>2/14</i> 19 <i>67</i> , and that death occurred at <i>9A</i> M, from the causes and on the date stated above.									
22a. SIGNATURE <i>W. L. Etienne</i>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>3/3/67</i>		
22c. PHYSICIAN'S NAME (Type) W. L. ETIENNE					22d. ADDRESS College Park Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment			23b. DATE THEREOF 3/6/67		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Mausoleum		23d. LOCATION (City, town or county) (State) Colmar Manor Md		
24. FUNERAL DIRECTOR Francis Gasch's Sons					ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR MAR 7 1967		
					25b. REGISTRAR'S SIGNATURE <i>James J. [unclear]</i>				

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

10/10/01 10/10/01

10/2/0

W. L. Etienne

[illegible]

1. *Chrysomelids*
 2. *Curculionids*
 3. *Chrysomelids*
 4. *Chrysomelids*
 5. *Chrysomelids*
 6. *Chrysomelids*
 7. *Chrysomelids*
 8. *Chrysomelids*
 9. *Chrysomelids*
 10. *Chrysomelids*
 11. *Chrysomelids*
 12. *Chrysomelids*
 13. *Chrysomelids*
 14. *Chrysomelids*
 15. *Chrysomelids*
 16. *Chrysomelids*
 17. *Chrysomelids*
 18. *Chrysomelids*
 19. *Chrysomelids*
 20. *Chrysomelids*
 21. *Chrysomelids*
 22. *Chrysomelids*
 23. *Chrysomelids*
 24. *Chrysomelids*
 25. *Chrysomelids*
 26. *Chrysomelids*
 27. *Chrysomelids*
 28. *Chrysomelids*
 29. *Chrysomelids*
 30. *Chrysomelids*
 31. *Chrysomelids*
 32. *Chrysomelids*
 33. *Chrysomelids*
 34. *Chrysomelids*
 35. *Chrysomelids*
 36. *Chrysomelids*
 37. *Chrysomelids*
 38. *Chrysomelids*
 39. *Chrysomelids*
 40. *Chrysomelids*
 41. *Chrysomelids*
 42. *Chrysomelids*
 43. *Chrysomelids*
 44. *Chrysomelids*
 45. *Chrysomelids*
 46. *Chrysomelids*
 47. *Chrysomelids*
 48. *Chrysomelids*
 49. *Chrysomelids*
 50. *Chrysomelids*
 51. *Chrysomelids*
 52. *Chrysomelids*
 53. *Chrysomelids*
 54. *Chrysomelids*
 55. *Chrysomelids*
 56. *Chrysomelids*
 57. *Chrysomelids*
 58. *Chrysomelids*
 59. *Chrysomelids*
 60. *Chrysomelids*
 61. *Chrysomelids*
 62. *Chrysomelids*
 63. *Chrysomelids*
 64. *Chrysomelids*
 65. *Chrysomelids*
 66. *Chrysomelids*
 67. *Chrysomelids*
 68. *Chrysomelids*
 69. *Chrysomelids*
 70. *Chrysomelids*
 71. *Chrysomelids*
 72. *Chrysomelids*
 73. *Chrysomelids*
 74. *Chrysomelids*
 75. *Chrysomelids*
 76. *Chrysomelids*
 77. *Chrysomelids*
 78. *Chrysomelids*
 79. *Chrysomelids*
 80. *Chrysomelids*
 81. *Chrysomelids*
 82. *Chrysomelids*
 83. *Chrysomelids*
 84. *Chrysomelids*
 85. *Chrysomelids*
 86. *Chrysomelids*
 87. *Chrysomelids*
 88. *Chrysomelids*
 89. *Chrysomelids*
 90. *Chrysomelids*
 91. *Chrysomelids*
 92. *Chrysomelids*
 93. *Chrysomelids*
 94. *Chrysomelids*
 95. *Chrysomelids*
 96. *Chrysomelids*
 97. *Chrysomelids*
 98. *Chrysomelids*
 99. *Chrysomelids*
 100. *Chrysomelids*

1. *Antennaria dioica*
 2. *Antennaria dioica*
 3. *Antennaria dioica*
 4. *Antennaria dioica*
 5. *Antennaria dioica*
 6. *Antennaria dioica*
 7. *Antennaria dioica*
 8. *Antennaria dioica*
 9. *Antennaria dioica*
 10. *Antennaria dioica*
 11. *Antennaria dioica*
 12. *Antennaria dioica*
 13. *Antennaria dioica*
 14. *Antennaria dioica*
 15. *Antennaria dioica*
 16. *Antennaria dioica*
 17. *Antennaria dioica*
 18. *Antennaria dioica*
 19. *Antennaria dioica*
 20. *Antennaria dioica*
 21. *Antennaria dioica*
 22. *Antennaria dioica*
 23. *Antennaria dioica*
 24. *Antennaria dioica*
 25. *Antennaria dioica*
 26. *Antennaria dioica*
 27. *Antennaria dioica*
 28. *Antennaria dioica*
 29. *Antennaria dioica*
 30. *Antennaria dioica*
 31. *Antennaria dioica*
 32. *Antennaria dioica*
 33. *Antennaria dioica*
 34. *Antennaria dioica*
 35. *Antennaria dioica*
 36. *Antennaria dioica*
 37. *Antennaria dioica*
 38. *Antennaria dioica*
 39. *Antennaria dioica*
 40. *Antennaria dioica*
 41. *Antennaria dioica*
 42. *Antennaria dioica*
 43. *Antennaria dioica*
 44. *Antennaria dioica*
 45. *Antennaria dioica*
 46. *Antennaria dioica*
 47. *Antennaria dioica*
 48. *Antennaria dioica*
 49. *Antennaria dioica*
 50. *Antennaria dioica*
 51. *Antennaria dioica*
 52. *Antennaria dioica*
 53. *Antennaria dioica*
 54. *Antennaria dioica*
 55. *Antennaria dioica*
 56. *Antennaria dioica*
 57. *Antennaria dioica*
 58. *Antennaria dioica*
 59. *Antennaria dioica*
 60. *Antennaria dioica*
 61. *Antennaria dioica*
 62. *Antennaria dioica*
 63. *Antennaria dioica*
 64. *Antennaria dioica*
 65. *Antennaria dioica*
 66. *Antennaria dioica*
 67. *Antennaria dioica*
 68. *Antennaria dioica*
 69. *Antennaria dioica*
 70. *Antennaria dioica*
 71. *Antennaria dioica*
 72. *Antennaria dioica*
 73. *Antennaria dioica*
 74. *Antennaria dioica*
 75. *Antennaria dioica*
 76. *Antennaria dioica*
 77. *Antennaria dioica*
 78. *Antennaria dioica*
 79. *Antennaria dioica*
 80. *Antennaria dioica*
 81. *Antennaria dioica*
 82. *Antennaria dioica*
 83. *Antennaria dioica*
 84. *Antennaria dioica*
 85. *Antennaria dioica*
 86. *Antennaria dioica*
 87. *Antennaria dioica*
 88. *Antennaria dioica*
 89. *Antennaria dioica*
 90. *Antennaria dioica*
 91. *Antennaria dioica*
 92. *Antennaria dioica*
 93. *Antennaria dioica*
 94. *Antennaria dioica*
 95. *Antennaria dioica*
 96. *Antennaria dioica*
 97. *Antennaria dioica*
 98. *Antennaria dioica*
 99. *Antennaria dioica*
 100. *Antennaria dioica*

Don't forget to take

2004/04/03

et al.

— 36 — 37

Volume 2

ST. 100 100

1000 JOURNAL OF DOCUMENTATION

2001-2002

College Park

• 225 •

College Park

0001 52. Andrews James

1

2000

Therese A. Kelly

১০-এ-৩৭ ০৩৭

10/10/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04006

CERTIFICATE OF DEATH

04005

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 days 5 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 2804 Belair Drive	
3. NAME OF DECEASED (Type or print) Susie F. Bedell		4. DATE OF DEATH Month March Day 31 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1875
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House hold		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (County & State, or foreign country) Brooklyn, New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David S. Brower		14. MOTHER'S MAIDEN NAME Susan M. Robinson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 241-84-2808-J	
17. INFORMANT Mrs. Suzie MacClary, Birmingham, Ala.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest. DUE TO (b) Acute Myocardial Infarction. DUE TO (c) Coronary Heart Disease.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that W (this hospital) attended the deceased from March 27, 1967 , to March 31, 1967 , that W (we) last saw the deceased alive on March 31, 1967 , and that death occurred at 3:02 P. from causes and on the date stated above.			
22a. SIGNATURE W. Hernandez, M.D.		22b. DATE SIGNED March 31, 1967	
22c. PHYSICIAN'S NAME (Type) W. Hernandez, M.D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF April 3, 1967	
23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d. LOCATION (City or Town) (County) (State) Brooklyn, New York	
24. FUNERAL DIRECTOR Harold S. Waddy, Laurel, Md.		25a. REC'D BY REGISTRAR DATE APR 3 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1347
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 18-21 Film G388 5/18/67 eac

Item 14 Film G 390 6/23/67 in

FOR STATE HEALTH DEPT

04007

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04006

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY P.G.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN TB 5 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1100 Main Street		d. STREET ADDRESS 106 Woodlawn Court	
3. NAME OF DECEASED (Type or print) First Middle Last Hazel Frances Bell		4. DATE OF DEATH Month Day Year 3 11 19 67	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 May 1913
9. AGE (In years last birthday) 53		10. IF UNDER 1 YEAR Months Days Hours Min. 11 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - -	
11. BIRTHPLACE (State or foreign country) Roanoke, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Lowery		14. MOTHER'S MAIDEN NAME Whipp/ Fannie Witt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. unk	
17. INFORMANT Mr. Stephen H. Bell, Same as #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exposure to cold DUE TO (b) 932.6 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Froze while sleeping in abandoned building	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. Unknown 3-6- 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work 1100 Main St.	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Laurel, Prince Geo., Maryland		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 3-12-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF March 15, 1967	
23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery,		23d. LOCATION (City or town) (County) (State) Roanoke, Virginia	
24. FUNERAL DIRECTOR Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland		25a. REC'D BY REGISTRAR MAR 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #3 Film #G388 1/25/67 ps

04008

CERTIFICATE OF DEATH

04007

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 44 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Lillian Pearl Lillian Pearl Bensen				4. DATE OF DEATH Month Day Year March 22 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 8/20/06	
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - -			
13. FATHER'S NAME James H. Eaton				14. MOTHER'S MAIDEN NAME Ella May Polen			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO.		17. INFORMANT Lawrence Eaton - Son Address Same as 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinoma DUE TO (b) Carcinoma, rt. breast DUE TO (c) 16 nos							INTERVAL BETWEEN ONSET AND DEATH 16 nos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/4 , 19 67 to 3/22 , 19 67 that (I) (we) last saw the deceased alive on 3/21 , 19 67 and that death occurred at 2:50 P.M., from causes and on the date stated above.							
22a. SIGNATURE Julius Kauffman				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED March 22, 1967	
22c. PHYSICIAN'S NAME (Type) Julius Kauffman, M.D.				22d. ADDRESS 6501 Landover Rd. Cheverly, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 3-22-67		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION (City or Town) (County) (State) Washington, D.C.	
24. FUNERAL DIRECTOR Lee Funeral Home. 300 4th. NE, Wash. DC				25a. REC'D BY REGISTRAR MAR 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00000

00000

Director of Colorado

George George

Washington

on duty

Executive

Prince George General Hospital

1907-1914 St. S. I.

Female

White

Married

James E. Taylor

Age

Lawrence Taylor

1907-1914

Postmaster General, Denver, Mo.

Business Department, St. P.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04009

CERTIFICATE OF DEATH

04008

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY 47-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 25 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.		d. STREET ADDRESS 4703 Windom Place, XXXXXXXXXX N.W.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Home, 5805 Queens Chapel Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Henrietta (NMI) Berckmann		4. DATE OF DEATH Month Day Year March 3 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 15, 1881 85
9. AGE (In years last birthday) yrs. 85		10. IF UNDER 1 YEAR Months Days Hours Min. 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) invalid - none		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME John G. Berckmann		14. MOTHER'S MAIDEN NAME Margaret Doyle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 220-44-8701	
17. INFORMANT Sacred Heart Home, Hyattsville, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Melanoma of Choroid of left eye DUE TO (b) with generalized metastases DUE TO (c) 192X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-10 , 19 63 , to 3-3 , 19 67 , that (I) (we) last saw the deceased alive on 3-3 , 19 67 , and that death occurred at 10:45 M, from causes and on the date stated above.			
22a. SIGNATURE Thomas F. Collins		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Thomas F. Collins		22d. ADDRESS 322 H St. N. E. Washington, DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Mar 6, 1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Washington, D. C.
24. FUNERAL DIRECTOR Joseph Gawler's Sons		25a. REC'D BY REGISTRAR MAR 9 1967	
ADDRESS Washington, D. C.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

MEDICAL CERTIFICATION

04008

04008

Director of Bureau

Director of Bureau

Director of Bureau

Director of Bureau

Director of Bureau

Director of Bureau

Director of Bureau

Director of Bureau

Director of Bureau

Director of Bureau

Director of Bureau

Director of Bureau

Director of Bureau

Director of Bureau

Director of Bureau

Director of Bureau

Director of Bureau

Director of Bureau

Director of Bureau

Director of Bureau

Director of Bureau

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04010

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04009

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN IB DOA		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d. STREET ADDRESS 1152 49th. Avenue		
3. NAME OF DECEASED (Type or print) Mark S Beuchert			4. DATE OF DEATH Month 3 Day 12 Year 19 67		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 Jan. 1960		9. AGE (In years lost birthday) yrs. 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Donald F. Beuchert			14. MOTHER'S MAIDEN NAME Shirley F. Curtin		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Donald F. Beuchert Address Same as Item #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Burns - 100 % of body surface 9160 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) Burned in house fire.			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 9:45pm p.m. 3-12- 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
		20f. (City or town) same as #2		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe		M.D.		22. DATE SIGNED 3-13-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 15-67		23c. NAME OF CEMETERY OR CREMATORY Washington Nat'l. Cem.	
				23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Simmons Bros.		ADDRESS 1661-Good Hope Rd SE Wash DC		25a. REC'D BY REGISTRAR MAR 15 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

04070

04000

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

04011

04010

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First David Middle Jeffrey Last Black				4. DATE OF DEATH Month March Day 31 Year 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-22-49		9. AGE (In years last birthday) 17 yrs.	IF UNDER 1 YEAR Months 16 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Maxwell Henry Black				14. MOTHER'S MAIDEN NAME Christine Lollis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Christine Lollis Stewart Address Same As # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of chest 9190 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH minutes							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by accidental discharge of rifle.					
20c. TIME OF INJURY Month, Day, Year 6:55PM 3-31-67 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 4666 Homer Ave.		20f. (City or town) (County) (State) Apt. B Suitland P.G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 4-1-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/4/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges, Maryland	
24. FUNERAL DIRECTOR Robert E. Wilhelm Address Funeral Home 4308 Suitland Rd. Suitland Maryland				25a. REC'D BY REGISTRAR APR 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01000

01000

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05565

CERTIFICATE OF DEATH

05564

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN IB 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS Old Crain 1200X Highway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ernest August Blank				4. DATE OF DEATH Month March Day 22 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 March 1889		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wood Finisher		10b. KIND OF BUSINESS OR INDUSTRY EMPLOYED Building Industry		11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME August C. Blank				14. MOTHER'S MAIDEN NAME Angolica Kuehney			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO. -----		17. INFORMANT William F. Blank-Cleveland 4, Ohio			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4110X Congestive Heart Failure w/ DUE TO Moderate pulmonary edema, below Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pneumonic heart disease w/ mitral (c) arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 17, 1967 , to March 22, 1967 , that (I) (we) last saw the deceased alive on March 22, 1967 , and that death occurred at 4:40AM from causes and on the date stated above.							
22a. SIGNATURE Edwin J. Jensen				22b. DATE SIGNED March 22, 1967		22c. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M.D.	
22d. ADDRESS Prince Georges General Hospital				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/27/67		23c. NAME OF CEMETERY OR CREMATORY Acacia Park Cemetery		23d. LOCATION (City or Town) (County) (State) Mayfield Heights, Ohio	
24. FUNERAL DIRECTOR Ritchie Bros. Fun'l Home-Maryland.				25a. REC'D BY REGISTRAR APR 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

02554

02554

Prince Georges

Prince Georges

Prince Georges

Upper Harbour

Upper Harbour

Upper Harbour

XXXX

XXXX

XXXX

XXXX

XXXX

12 March 1980

12

12

12

U.S.A.

Ohio

Ohio

Ohio

XXXX

XXXX

XXXX

XXXX

XXXX

XXXX

XXXX

XXXX

XXXX

XXXX

XXXX

XXXX

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04012

CERTIFICATE OF DEATH

04011

1. PLACE OF DEATH a. COUNTY <u>PR. GEORGE'S</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON (SIX) DAYS</u>		c. LENGTH OF STAY IN 1b <u>16-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>So. MARYLAND GEN. HOSP.</u>		d. STREET ADDRESS <u>4751 Hagan Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>ALICE L BOORMAN</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-6-1885</u>
9. AGE (In years last birthday) <u>82</u> yrs.		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. gov</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		13. FATHER'S NAME <u>William H. Adams</u>	
14. MOTHER'S MAIDEN NAME <u>Alice Mc Daniel</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Virginia Talbert (Niece) St Barnabas Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>Cardiovascular arteriosclerosis</u> DUE TO <u>Hypertensive disease</u> (c) <u>Hypertensive disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-14</u> , 19 <u>67</u> , to <u>3-16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-16</u> , 19 <u>67</u> , and that death occurred at <u>10:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred R. Lapin MD</u>		22b. DATE SIGNED <u>3-16-1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN MD</u>		22d. ADDRESS <u>CLINTON, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 20-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill, Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>Simmons Bros.</u>		25a. REC'D BY REGISTRAR <u>MAR 21 1967</u>	
ADDRESS <u>1661-Gd. Hope Rd. SE. Wash., DC</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11030

\$1080

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (9)
20 M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G387 3/28/67 DC

04013

CERTIFICATE OF DEATH

04012

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE 2328 25th St. S.E. Wash., D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton, Md.		c. LENGTH OF STAY IN Ib 6 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wash., D.C.		d. STREET ADDRESS Stuart Lane-Clinton, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pineview Gardens Health Care Center		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bossler, Annie M.		4. DATE OF DEATH Month March Day 18 Year 19 67	
5. SEX F	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/24/81
9. AGE (In years last birthday) 85 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Birds Born, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Redcay		14. MOTHER'S MAIDEN NAME Alice McCalicker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. n one	
17. INFORMANT Niece Mrs. Brady Bishop		Address (Marlow Hts., Md.) 59 31 28th Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) Generalized arteriosclerosis DUE TO (c) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus, insulin		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) no		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/21 , 19 67 , to 3/18 , 19 67 , that (I) (we) lost saw the deceased alive on 19 , and that death occurred at M , from causes on and on the date stated above.			
22a. SIGNATURE Henry J. Bloer		22b. DATE SIGNED 3/18/67	
22c. PHYSICIAN'S NAME (Type) Dr. Henry Palacios		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3-21-67	23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN	23d. LOCATION (City or Town) (County) (State) COLMAR MANOR MD.
24. FUNERAL DIRECTOR Lee's Funeral Home		25a. REC'D BY REGISTRAR MAR 22 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

81020

REAR 11 HARRIS

81040

P A C E

T T T

C

C

-

P C

C

*

T T T

C

C

C

T T

REAR 11 HARRIS

REAR 11 HARRIS

REAR 11 HARRIS

REAR 11 HARRIS

REAR 11 HARRIS

REAR 11 HARRIS

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04014

04013

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TDWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights			
c. LENGTH OF STAY IN 1b DOA				d. STREET ADDRESS 5110 Nash Street			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital							
3. NAME OF DECEASED (Type or print) First Middle Last William Orthello Bradley				4. DATE OF DEATH Month Day Year 3 7 19 67			
5. SEX Male		6. COLOR OR RACE negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-28-1966	
9. AGE (In years last birthday) yrs. 2		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None			
13. FATHER'S NAME William O. Bradley				14. MOTHER'S MAIDEN NAME Kera Hiers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address William O. Bradley - Farmer			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 522X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SDII DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D.				22. DATE SIGNED 3-8-67			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) 3-10-67		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Lincoln Cem.		23d. LOCATION (City or Town) (County) (State) Southland Md	
24. FUNERAL DIRECTOR H.S. Washington & Sons				25a. REC'D BY REGISTRAR MAR 13 1967			
ADDRESS 4925 Deane Ave N.E.				25b. REGISTRAR'S SIGNATURE Charles Judge			

6-197999

04013

04013

George Washington

George Washington

George Washington

George Washington

George Washington

George Washington

George Washington

George Washington

1

2

3

George Washington

George Washington

George Washington

George Washington

George Washington

George Washington

George Washington

George Washington

George Washington

George Washington

George Washington

George Washington

George Washington

George Washington

George Washington

1801

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04016

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04014

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital			d. STREET ADDRESS 3233 75th Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Godfrey Alvin Brower			4. DATE OF DEATH Month Day Year March 10 19 67		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1952	9. AGE (In years last birthday) 14 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Washington D. C.	
13. FATHER'S NAME Godfrey C Brower			14. MOTHER'S MAIDEN NAME Louise C Mc Cauley		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Godfrey C Brower Address Landover, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrocution DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 9145					INTERVAL BETWEEN ONSET AND DEATH minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Became entangled in guide wire of radio antenna which touched high-voltage wire.			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10:41 PM m. 3-10-67 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) In front of 3385 Dodge Park Rd. P.G. Md.	
20f. (City or town) (County) (State) Landover Prince George's Maryland					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 3-11-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 13, 1967		23c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery	
23d. LOCATION (City or Town) Washington D. C.		23e. (County) (State) Prince George's Maryland		23f. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR MAR 14 1967	

MEDICAL CERTIFICATION

01010

01010

Prince George

Barrow

Barrow

Barrow

DO

Barrow

Barrow

Barrow

March 10

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

Barrow

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

301-51

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04015

CERTIFICATE OF DEATH

04015

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland c. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN TB 9 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS Box 388		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Nellie - Brown				4. DATE OF DEATH Month Day Year March 30 1967			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/11/30	
9. AGE (In years lost birthday) 36 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		11. BIRTHPLACE (County & State, or foreign country) Prince George's Co. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Issac A. Brown				14. MOTHER'S MAIDEN NAME Isabell Scott			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address John Brown Rt. 3-Box 124 Brandywine, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 092 x Chronic Encephalopathy secondary to long to Infectious Hepatitis DUE TO (b) Chronic 2nd liver secondary to alcoholism DUE TO (c) Chronic 2nd liver secondary to alcoholism PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) to alcoholism							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 21, 1967 , to March 30, 1967 , that (I) (we) last saw the deceased alive on March 30, 1967 , and that death occurred at 9:40 AM from causes and on the date stated above.							
22a. SIGNATURE J. A. Garcia, M.D.				22b. DATE SIGNED 3/31/67		22c. PHYSICIAN'S NAME (Type) J. A. GARCIA, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF April 3/67		23c. NAME OF CEMETERY OR CREMATORY St. Peters Church Cem.	
23d. LOCATION (City or Town) (County) (State) Waldorf Chas. Co. Md.				23e. REC'D BY REGISTRAR APR 6 1967		23f. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR Martell Adams				24b. ADDRESS Aquasco, Maryland			

00015

LETTER OF CREDIT

00015

Prince George

Barbados

Prince George

Barbados

7 days

Barbados

Box 388

Prince George General Hospital

Brown

Belle

8/11/30

xx

Colored

Female

55

010001

March 31

March 31

March 31

Prince George General Hospital

J. J. JACOB, M.D.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04016

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greenbelt Convalescent Center</u>		d. STREET ADDRESS <u>4313 Sheridan St.</u>	
3. NAME OF DECEASED (Type or print) <u>INEZ</u> First <u>M.</u> Middle <u>BROWNELL</u> Last		4. DATE OF DEATH <u>March</u> Month <u>15</u> Day <u>1967</u> Year	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1 - 1874</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		9b. AGE (In years last birthday) <u>92</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone Company</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Arin C Brownell</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Gilman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-05-0373</u>	
17. INFORMANT <u>Lucille P Wiesemaner</u> Address <u>Hyattsville</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis of Disease</u> DUE TO <u>5 yrs.</u> (c) <u>General arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> to <u>Mar 15, 1967</u> , that (I) (we) last saw the deceased alive on <u>Mar 1, 1967</u> , and that death occurred at <u>11:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>L.W. Malin</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Mar 16, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>L.W. Malin M.D.</u>		22d. ADDRESS <u>Riversdale, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 18, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor P.D. Geo Md</u>	
24. FUNERAL DIRECTOR <u>F. Caschi sons</u> ADDRESS <u>Hyattsville Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 20 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00010

OFFICE OF THE

00010

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04018

04017

1. PLACE OF DEATH a. COUNTY <u>Prince Geo.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3925 Livingston Rd</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Geo.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>3925 Livingston Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALFRIEDA</u> Middle <u>BRUEHL</u> Last <u>BRUEHL</u>		4. DATE OF DEATH <u>3/30/67</u> 19 <u>67</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAUC</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 24, 1881</u> 85 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (County & State, or foreign country) <u>SIABRUEK, GERMANY</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>UNK</u>	
14. MOTHER'S MAIDEN NAME <u>UNK</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>REV. FR JOHN QUASTEN, CATHOLIC UNIV. WASH. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> (c) <u>Arteriosclerosis</u> DUE TO DUE TO DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Apr 4, 1966</u> , to <u>Nov. 30, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov. 26, 1967</u> , and that death occurred at <u>4:15</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas J. Kelly</u>		22b. DATE SIGNED <u>Nov. 31, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS J. KELLY, M.D.</u>		22d. ADDRESS <u>6480 N. H. Ave., Takoma Park, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/3/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE</u>		23d. LOCATION (City, town or county) (State) <u>WASH. D.C.</u>	
24. FUNERAL DIRECTOR <u>Chas. H. D. C.</u>		ADDRESS	
25a. REC'D BY REGISTRAR <u>APR 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

06017

06018

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04019 CERTIFICATE OF DEATH 04018

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DO. b. COUNTY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Forestville		c. LENGTH OF STAY IN 1b 17 Days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington, DO. 47-3			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Regent Nursing Home				d. STREET ADDRESS 3330- 12th Street SE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) OCIE BUNNER				4. DATE OF DEATH Month March 18th 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 18th 1887 79 yrs.	
9. AGE (in years last birthday) 79		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Clerk		10b. KIND OF BUSINESS OR INDUSTRY Peoples Drug		11. BIRTHPLACE (County & State, or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Charles D. Powell			
14. MOTHER'S MAIDEN NAME Margaret Galvin				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO.				17. INFORMANT William H. Bunner (Son) Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emboli 332X DUE TO (b) Cerebral Vascular Thrombosis - 6 DUE TO (c) Left hemiplegia, Arterio Sclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-2, 1967, to 3-18, 1967, that (I) (we) last saw the deceased alive on 3-18, 1967, and that death occurred at 9-PM, from the causes and on the date stated above.							
22a. SIGNATURE John F. Shay				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED March 18- 67	
22c. PHYSICIAN'S NAME (Type) John F. Shay				22d. ADDRESS Suitland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 23-1967		23c. NAME OF CEMETERY OR CREMATORY Bluemont Cemetery		23d. LOCATION (City, town or county) (State) Grafton, West Virginia	
24. FUNERAL DIRECTOR Simmons Bros.				ADDRESS 1661-Gd. Hope Rd. SE. Wash., DC		25a. REC'D BY REGISTRAR MAR 21 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

02018

02018

John F. Sherry

MAR 21 1951

MAR 23 1951

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05577

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b. 4-Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Adsacorda Nursing Home				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Mitchellville Md 46.1 d. STREET ADDRESS 2601 Cheverly Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle -- Last Burroughs		4. DATE OF DEATH Month March Day 24, Year 1967		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH May 18, 1872 9. AGE (In years last birthday) 94 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Empl'd Clerk 10b. KIND OF BUSINESS OR INDUSTRY Nat'l Geographic Magazine 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John William Burroughs 14. MOTHER'S MAIDEN NAME Mary Posey		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. ----- 17. INFORMANT Mrs. Adeline B. Shrewsbury Address RFD Box 2725, Upper Marlboro, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 DUE TO Cerebral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Interdiction - Generalized severe DUE TO (c) 15 yrs				INTERVAL BETWEEN ONSET AND DEATH 3 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 1967 to 24 Nov 1967 , that (I) (we) last saw the deceased alive on 22 Nov 1967 , and that death occurred at 2:20 A.M. from the causes and on the date stated above.							
22a. SIGNATURE 22c. PHYSICIAN'S NAME (Type) Robert B. Sasscer, M. D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Upper Marlboro, Maryland 20870		22b. DATE SIGNED 3/24/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 3/24/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory			
24. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.		25a. REC'D BY REGISTRAR APR 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05277

17. 1901

17. 1901

17. 1901

17. 1901

17. 1901

17. 1901

17. 1901

17. 1901

17. 1901

17. 1901

17. 1901

17. 1901

17. 1901

17. 1901

17. 1901

17. 1901

17. 1901

17. 1901

17. 1901

17. 1901

17. 1901

17. 1901

17. 1901

17. 1901

17. 1901

17. 1901

17. 1901

17. 1901

17. 1901

17. 1901

17. 1901

17. 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04020

CERTIFICATE OF DEATH

04019

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. LENGTH OF STAY IN 1b <u>15 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>		d. STREET ADDRESS <u>16-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pine View Gardens Health Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Gertrude K. Burton</u>		4. DATE OF DEATH <u>March 15 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-28-81</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAITRESS - RET.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STORE CAFETERIA</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>IRELAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID KEARNEY</u>		14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>4201</u>	
17. INFORMANT <u>Joseph E. Burton</u>		Address <u>6561 Rock Terrace Oxon Hill</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO <u>Coronary Collapsus</u> (b) <u>Coronary Insufficiency + Arteriosclerosis</u> (c) <u>Heart Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-3-67</u> , to <u>3-15-67</u> , that (I) (we) last saw the deceased alive on <u>3-15-67</u> , and that death occurred at <u>4:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred R. Lapin</u> M.D.		22b. DATE SIGNED <u>3-15-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, M.D.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-20-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>
24. FUNERAL DIRECTOR <u>Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Funeral Home</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

01090

INSTRUMENT OF DEED

00000

Blank document with faint horizontal lines and a large circular stamp in the center.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

04021

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G387 4/10/67 pc

CERTIFICATE OF DEATH

04020

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 day	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheltenham		d. STREET ADDRESS Box 4102 Frank Tippet Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary E Butler		4. DATE OF DEATH Month Day Year March 28 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1892
9. AGE (In years last birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KINO OF BUSINESS OR INOUSTRY		11. BIRTHPLACE (County & Stote, or foreign country) Prince Georges Co. Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Rhyanelder Butler	
14. MOTHER'S MAIDEN NAME Emily Mitchell		15. WAS DECEASED EVER IN U.S. ARMEO FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Clarence Butler P.O. Box 25	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma DUE TO (b) Adenocarcinoma of Rectum DUE TO (c) Return		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURREO While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (Stote)	
21. I certify that xx (this hospital) attended the deceased from March 27, 1967 , to March 28, 1967 , that xx (we) last saw the deceased alive on March 28, 1967 , and that death occurred at 4:50 PM , from causes and on the date stated above.			
22a. SIGNATURE J. A. Garcia, M.D.		22b. DATE SIGNED 3/27/67	
22c. PHYSICIAN'S NAME (Type) J. A. Garcia, M.D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 1-1967	
23c. NAME OF CEMETERY OR CREMATORY Brooks Church Cem.		23d. LOCATION (City or Town) (County) (Stote) Nottingham Pr. Geo. Md.	
24. FUNERAL DIRECTOR Martell Adams Aguas, Md.		25a. REC'D BY REGISTRAR APR 6 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

04020

04020

Prince George's General Hospital
Donor: Mrs. J. H. Smith
Date: 1954

Donor: Mrs. J. H. Smith
Date: 1954

Donor: Mrs. J. H. Smith
Date: 1954

Donor: Mrs. J. H. Smith
Date: 1954

Donor: Mrs. J. H. Smith
Date: 1954

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04022

04021

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5711 Jamestown Road</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>5711 Jamestown Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>David Mannie Callis</u>		4. DATE OF DEATH Month Day Year <u>March 5 1967</u>		5. SEX <u>male</u>									
6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/25/1876</u>									
9. AGE (In years last birthday) <u>91</u> yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor G.M.O. R.R. (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Alabama</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.											
Months	Days	Hours	Min.										
11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Harrison R. Callis</u>									
14. MOTHER'S MAIDEN NAME <u>Elizabeth Brown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>718-07-6493</u>									
17. INFORMANT Address <u>Kathleen C. McManus (same as above)</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure</u> (b) <u>General Arteriosclerosis</u> (c) <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>Years</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from..... 19<u>52</u> to..... <u>3/5</u> <u>67</u>, that (I) (we) last saw the deceased alive on..... <u>2/28</u> <u>1967</u>, and that death occurred at..... <u>4:30</u> P.M., from the causes and on the date stated above.													
22a. SIGNATURE <u>David S. Clayman</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. ADDRESS <u>6311 Balto. Ave Riverdale, Md</u>									
22c. PHYSICIAN'S NAME (Type) <u>David S. Clayman</u>		22d. DATE SIGNED <u>3/5/67</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE THEREOF <u>3/7/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Magnolia Cemetery</u>									
23d. LOCATION (City, town or county) (State) <u>Meridian, Mississippi</u>		24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>The S. H. Hines Company Washington, DC</u>											
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18001

00000

STATE OF TEXAS

David

1/1/10

1/1/10

1/1/10

1/1/10

1/1/10

1/1/10

1/1/10

1/1/10

1/1/10

1/1/10

1/1/10

1/1/10

1/1/10

1/1/10

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04023

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04022

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn 75-3	
c. LENGTH OF STAY IN 1b 45 min.		d. STREET ADDRESS Howellville Road 460 Howellville Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Fleming Last Carter		4. DATE OF DEATH Month March Day 10 Year 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-14-45
9. AGE (In years lost birthday) 21 yrs.		10. IF UNDER 1 YEAR Months 10 Days 19 Hours 19 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		11b. KIND OF BUSINESS OR INDUSTRY	
12. CITIZEN OF WHAT COUNTRY? USA		13. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Wilmer G. Carter		14. MOTHER'S MAIDEN NAME Margaret E. Gibson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-44-0203	
17. INFORMANT Wilmer G. Carter (Father)		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-abdominal hemorrhage 8164 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Trauma DUE TO (c) Auto accident INTERVAL BETWEEN DEATH minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car involved in head-on collision.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11:50PM m 3-10-67 19		20d. INJURY OCCURRED 2 While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) U.S. Rt. 1 at intersection of Rt. 193		20f. (City or town) (County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 3-11-67 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 13/1967	
23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Cockeysville, Md.	
24. FUNERAL DIRECTOR Eugenia K. Seitz 5209 York Road Seitz Funeral Home Balto. Md. 21212		25a. REC'D BY REGISTRAR MAR 13 1967 25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

SS010

02053

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #11 info. taken from birth cert.

04024

CERTIFICATE OF DEATH

04023

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 10 hrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Oaks		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 1303 - 58th Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Chinn		4. DATE OF DEATH Month March Day 3 Year 19 67	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1967
9. AGE (In years lost birthday) yrs. 10		IF UNDER 1 YEAR Months Days Hours Min. 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Pr. Geo. Co., Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jack Isaac Chinn		14. MOTHER'S MAIDEN NAME Roseal Marie Merritt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7625 Electroclasis neonatorum DUE TO (b) Prematurity DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 3, 1967 , to March 3, 1967 , that (I) (we) last saw the deceased alive on March 3, 1967 , and that death occurred at 3:00 PM from causes and on the date stated above.			
22a. SIGNATURE Andrew G. Aronfy, M.D.		22b. DATE SIGNED 3-6-67	
22c. PHYSICIAN'S NAME (Type) Andrew G. Aronfy, M.D.		22d. ADDRESS 6803 Good Luck Road, New Carrollton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 3/11/67	23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen Hosp.	23d. LOCATION (City or Town) (County) (State) Cheverly PG Maryland
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin.		25a. REC'D BY REGISTRAR MAR 15 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

04039

ESTIMATE OF DEATH

04039

at time reported

estimated

age

Prince Georges

1901-1902

in 1901

1901-1902

1901-1902

Prince Georges General Hospital

1901-1902

1901-1902

1901-1902

1901-1902

Colored

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

1901-1902

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD
1
4
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04025

CERTIFICATE OF DEATH

04024

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> <u>473</u>		d. STREET ADDRESS <u>2221 30th St. S.E.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Southern Md Hosp Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John L. CLARK</u>		4. DATE OF DEATH <u>MARCH 27</u> 19 <u>67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>8-15-1884</u>
9. AGE (In years last birthday) <u>82</u> yrs.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>State Dept</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		14. MOTHER'S MAIDEN NAME <u>Ida Virginia Sheats</u>	
13. FATHER'S NAME <u>William Frank Clark</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>579-44-6093</u>		17. INFORMANT <u>MRS. ROZETTA B LARRISON AS. D.</u> Address <u>SAME</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X Uremia</u> DUE TO (b) <u>Renal Failure</u> DUE TO (c) <u>Cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/24</u> , 19 <u>67</u> , to <u>3/27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/27</u> , 19 <u>67</u> , and that death occurred at <u>7:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred Laphin MD</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-30-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Switzland Md</u>	
24. FUNERAL DIRECTOR <u>LEE FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>APR 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

45040

CERTIFICATE OF DEATH

45040

STATE OF TEXAS

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

CERTIFICATE OF DEATH

45040

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04026

04025

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN Tb 4 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 6800 96th Avenue	
3. NAME OF DECEASED (Type or print) Jean (Jeanette) Cohen		4. DATE OF DEATH March 27 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 Aug., 1905
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Scranton Pa		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Samuel Katz		14. MOTHER'S MAIDEN NAME Anna ---	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 416X IMMEDIATE CAUSE (a) Multiple pulmonary Emboli. DUE TO (b) Rheumatic Heart Disease: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Congestive Heart failure.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that XX (this hospital) attended the deceased from March 23 , 19 67 , to March 28 , 19 67 , that XX (we) last saw the deceased alive on 3/28/67 19 67 , and that death occurred at 6:50AM from causes and on the date stated above.			
22a. SIGNATURE V. Hernandez MD		22b. DATE SIGNED March 28, 1967	
22c. PHYSICIAN'S NAME (Type) V. HERNANDEZ, M.D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 3-30-67	23c. NAME OF CEMETERY OR CREMATORY Mt. Sharon Cemetery	23d. LOCATION (City or Town) (County) (State) Delaware County, Penna.
24. FUNERAL DIRECTOR Bernard Danzansky & Sons St. Wash. D.C.		25a. REC'D BY REGISTRAR MAR 30 1967	25b. REGISTRAR'S SIGNATURE J Charles Judge

04052

04052

INVESTIGATION OF DEATH

Principal

Investigator

Witness

4 days

Coroner

5000 North Avenue

Philadelphia General Hospital

Jan 11, 1905

Female White

54 1/2 lbs

5' 10" tall

Multiple painless cysts

Chronic heart disease

Complete heart failure

Jan 11, 1905

Box 1

V. R. HARRIS, M.D.

Police Surgeon General Hospital

Dr. J. H. HARRIS, M.D.

Box 1

10 1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04027

CERTIFICATE OF DEATH

04026

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights		c. LENGTH OF STAY IN 1b 12 Years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights, Maryland		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3018- Curtis Drive SE.		d. STREET ADDRESS 3018- Curtis Drive SE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Nicolo		4. DATE OF DEATH March 2nd. 19 67	
First Middle Last Cono			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 11-1890
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Sealbest Dairy		10b. KIND OF BUSINESS OR INDUSTRY Dairy	
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Wife Angelina Cono		Address Same as Item #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident. 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Vascular disease. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov, 1966, to 3-2, 1967, that (I) (we) last saw the deceased alive on 3-2 1967, and that death occurred at 1140 M, from causes and on the date stated above.			
22a. SIGNATURE F. Taleghani M.D.		22b. DATE SIGNED March 3-67	
22c. PHYSICIAN'S NAME (Type) M. Far Taleghani		22d. ADDRESS 3611 -Branch Ave., SE Hillcrest Hghts Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-6-1967	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg, Md.	
24. FUNERAL DIRECTOR Simmons Bros. Simmons Bros. 1661-Good Hope Rd SE Wash DC		25a. REC'D BY REGISTRAR DATE MAR 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04008

RECEIVED 10 10 1961

04008

MAR 8 1961

00057

CERTIFICATE OF DEATH

00057

NAME OF DECEASED *John Doe*

DATE OF DEATH *10/10/1910*

PLACE OF DEATH *City of New York*

Cause of Death *Heart Disease*

Signature of Physician *[Signature]*

Signature of Registrar *[Signature]*

Signature of Coroner *[Signature]*

Signature of Medical Examiner *[Signature]*

Signature of Burial Officer *[Signature]*

Signature of Undertaker *[Signature]*

Signature of Funeral Home *[Signature]*

Signature of Cemetery *[Signature]*

Signature of City Clerk *[Signature]*

Signature of Mayor *[Signature]*

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04028

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04028

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN TB DOA		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d. STREET ADDRESS 12325 Tilbury Lane		
3. NAME OF DECEASED (Type or print) First Middle Last Gertrude Minnie Cronin			4. DATE OF DEATH Month Day Year 3 15 19 67		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-26-1903		9. AGE (In years lost birthday) yrs. 63
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) never worked		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Georgia	
13. FATHER'S NAME Isadore Koppel			14. MOTHER'S MAIDEN NAME Hannah Manne		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 067-38-8346		17. INFORMANT Address Paul R. Morrissey - same as #2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 443X DUE TO Hypertensive arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH minutes over 5 yrs.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 3-15-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial		23b. DATE THEREOF Mar. 16, 1967		23c. NAME OF CEMETERY OR CREMATORY Mount Hope	
23d. LOCATION (City or Town) Brooklyn		23e. LOCATION (County) New York		23f. LOCATION (State) New York	
24. FUNERAL DIRECTOR Beverly E. Hopping		25a. REC'D BY REGISTRAR MAR 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	
HOPPING FUNERAL HOME - Annapolis, Md.					

85630

25020

1. *Introduction*

1. *Journal of Management Studies*, 1991, 28, 1, 1-15.

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

2009-10-10

[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #7 Film #G387 4/3/67 pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04030

04029

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 8401 Allendale Drive.	
3. NAME OF DECEASED (Type or print) First Middle Last George Henry Cummings		4. DATE OF DEATH Month Day Year 3 19 67	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-23-1911
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Cummings		14. MOTHER'S MAIDEN NAME Minnie Highsmith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH minutes unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 3-20-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 3/23/67	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State) Wilmington N. C.
24. FUNERAL DIRECTOR Lee Funeral Home		25a. REC'D BY REGISTRAR MAR 22 1967	
ADDRESS Washington, Dc.		25b. REGISTRAR'S SIGNATURE Charles Judge	

03020

03020

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04031

04030

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown 03-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital			d. STREET ADDRESS Route 5, Old Court Road		
3. NAME OF DECEASED (Type or print) First Middle Last Robert Earl Cunningham			4. DATE OF DEATH Month Day Year 3 11 1967		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1945		9. AGE (In years lost birthday) 21 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Howard Cunningham			14. MOTHER'S MAIDEN NAME Madeline Ridgely		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 216-44-2440		17. INFORMANT Address Mr. Howard Cunningham - Balto. 7, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain DUE TO 8164 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Skull fracture DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) passenger in right front seat of car involved in collision			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 11:50pm 3-10 1967		20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) U.S. Rte. 1 at Rte. 193	
				20f. (City or town) (County) (State) P.G. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		22. DATE SIGNED 3-11-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-14-67		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery	
				23d. LOCATION (City or Town) (County) (State) Elkridge Md.	
24. FUNERAL DIRECTOR Harry W. Haight		ADDRESS Sylkesville, Md.		25a. REC'D BY REGISTRAR MAR 16 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

06020

25030

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #11, 12, 13 & 14 Film #G387 1/3/67 DC

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04032

04031

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS Rt. 301, Box 4981	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Brenda Middle Lois Last Curtis		4. DATE OF DEATH Month 3 Day 25 Year 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 Jan. 1950
9. AGE (In years lost birthday) 17 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ottway Curtis		14. MOTHER'S MAIDEN NAME Mildred Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 981X IMMEDIATE CAUSE (a) Gun shot wound of neck DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) Shot by assailant.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 5:45pm p.m. 3-25- 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) same as #2 (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 3-27-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 4-1-67	23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel	23d. LOCATION (City or town) (County) (State) Upper Marlboro Md
24. FUNERAL HOME Rollins Funeral Home		25a. REC'D BY REGISTRAR MAR 29 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

16040

16040

17 20 Jan, 1950

17 20 Jan, 1950

17 20 Jan, 1950

17 20 Jan, 1950

17 20 Jan, 1950

17 20 Jan, 1950

17 20 Jan, 1950

17 20 Jan, 1950

17 20 Jan, 1950

17 20 Jan, 1950

17 20 Jan, 1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04033

CERTIFICATE OF DEATH

04032

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE MD</u>		c. LENGTH OF STAY IN Tb <u>8 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL MANOR 4922 LA SALLE RD</u>		d. STREET ADDRESS <u>8411 GALVENTON RD.</u>	
3. NAME OF DECEASED (Type or print) <u>ISABEL</u>		4. DATE OF DEATH Month <u>3</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-30-82</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Thatcher's Luthers</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES FITZPATRICK</u>		14. MOTHER'S MAIDEN NAME <u>EMILY DEMONET</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-01-6012</u>	
17. INFORMANT <u>Dr. Magallanes</u>		Address <u>Germine Pearson</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>8 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 30</u> , 19 <u>59</u> , to <u>Mar 29</u> , 19 <u>67</u> , that (I) (<u>was</u>) last saw the deceased alive on <u>Mar 29</u> , 19 <u>67</u> , and that death occurred at <u>6:28</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Francis P. Hannan M.D.</u>		22b. DATE SIGNED <u>Mar 29, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANCIS P. HANNAN</u>		22d. ADDRESS <u>1511-17 ST. N.W. WASH. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Interment</u>	23b. DATE THEREOF <u>Mar 31-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Elizabeth Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>
24. FUNERAL DIRECTOR <u>Sakoma Funeral Home</u>		25a. REC'D BY REGISTRAR <u>MAR 31 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

04033

DEPARTMENT OF HEALTH

04033

7

MAR 31 1964

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04034

04033

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arden			
c. LENGTH OF STAY IN 1b DOA				d. STREET ADDRESS 8646 Johnson Ave.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary L. Deadwyler				4. DATE OF DEATH Month Day Year 3 2 19 67			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-18-1904	
9. AGE (In years last birthday) 62 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSE WIFE		11. BIRTHPLACE (State or foreign country) GEORGIA	
12. CITIZEN OF WHAT COUNTRY? GEORGIA				13. FATHER'S NAME JIM FOOTE			
14. MOTHER'S MAIDEN NAME EMMA HITCHCOCK				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT HEROY DEADWYLER Address 8646 Johnson Ave Glen Arden			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ OUE TO _____							INTERVAL BETWEEN ONSET AND DEATH minutes over 2 yrs.
PART II. OTHER SIGNIFICANT CONITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
22. DATE SIGNED 3-2-67				23. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county)				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Mar. 6, 67		23c. NAME OF CEMETERY OR CREMATORY Carver Cemetery		23d. LOCATION (City or Town) (County) (State) Md.	
24. FUNERAL DIRECTOR Shades E. Hunter 2512 Sheridan Rd				25a. REC'D BY REGISTRAR April 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

00000

00000

James George's

University

James George's

James George's

1

James George's

James George's

James George's

1

James George's

James George's

James George's

James George's

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04035

CERTIFICATE OF DEATH

04034

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 8 hrs.45 min.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 6407 Jay Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Deal		4. DATE OF DEATH Month March Day 4 Year 67	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 4, 1967
9. AGE (In years last birthday) yrs. 8		IF UNDER 1 YEAR Months 8 Days 19 Hours 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Prince George's, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Leo Queen		14. MOTHER'S MAIDEN NAME Janice Sheila Deal	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mother		Address As above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 7625 IMMEDIATE CAUSE (a) Pulmonary atelectasis DUE TO (b) Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/4/ , 19 67 , to 3/4/ , 19 67 , that (I) (we) last saw the deceased alive on March 4, 19 67 , and that death occurred at 10:45 AM, from causes and on the date stated above.			
22a. SIGNATURE Andrew G. Aronfy M.D.		22b. DATE SIGNED 3-6-67	
22c. PHYSICIAN'S NAME (Type) Andrew G. Aronfy		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 3/11/67	
23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp.		23d. LOCATION (City or Town) (County) (State) Cheverly PG, Maryland	
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin.,		25a. RECEIVED BY REGISTRAR MAR 15 1967	
25b. SIGNATURE Harry W. Penn, Jr., Admin.,		25c. SIGNATURE Harry W. Penn, Jr., Admin.,	

DEOD

23020

8-178-02-201-3

Andrew G. Brown
Director of Property

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04036

CERTIFICATE OF DEATH

04035

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			c. LENGTH OF STAY IN TB <u>2 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>15-2</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hyattsville Nursing Home - 6500 Rig</u>				d. STREET ADDRESS <u>14706 New Hampshire Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Blanche</u> Middle <u>M</u> Last <u>Deane</u>				4. DATE OF DEATH Month <u>march</u> Day <u>15</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/20/1884</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during usual of waking life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Nova Scotia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Murphy</u>				14. MOTHER'S MAIDEN NAME <u>Mary Mooney</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>022-40-0236</u>		17. INFORMANT <u>Daughter-in-law</u> Address <u>14706 New Hampshire Ave Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO <u>Recurring Cerebral Vase Accidents</u> DUE TO <u>Generalized Atherosclerosis</u> stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>miss.</u> <u>weeks</u> <u>years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 17</u> , 19 <u>67</u> , to <u>march 15</u> , 19 <u>67</u> , that (we) lost the deceased on <u>march 15</u> , 19 <u>67</u> , and that death occurred at <u>10:00</u> A.M. from causes and on the date stated above.							
22a. SIGNATURE <u>Harold W. Draper</u> M.D.				22b. DATE SIGNED <u>15 March 67</u>		22c. PHYSICIAN'S NAME (Type) <u>HAROLD W. DRAPER</u>	
22d. ADDRESS <u>911 SILVER SPRING AVE, SILVER SPRING, MARYLAND</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>3/15/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY - COLMAR MANOR</u>		23d. LOCATION (City or Town) (County) (State) <u>MD</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBER, INC. SILVER SPRING, MD</u>				25a. REC'D BY REGISTRAR <u>MAR 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01035

ESTIMATE OF COSTS

01035

[Faint, illegible text, likely bleed-through from the reverse side of the page. The text appears to be organized into sections or paragraphs, but the specific words are not discernible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04037

CERTIFICATE OF DEATH

04036

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>B.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland City</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Laurel General Hosp</u>		d. STREET ADDRESS <u>3358 Old Line Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Gabriel F. DeAngelis</u>		4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 8 1879</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>superintendent maint</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>newspaper</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York City, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Francis DeAngelis</u>		14. MOTHER'S MAIDEN NAME <u>Mary Cloppinger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>110-07-25904</u>	
17. INFORMANT <u>Marguerite Muller, Laurel Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesenteric artery thromboses</u> 4500 DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>Feb. 1, 1965</u> , to <u>3-17-</u> , 1967 that (1) (we) last saw the deceased alive on <u>3/16 1967</u> , and that death occurred at <u>11:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Frank Weaver Jr.</u>		22b. DATE SIGNED <u>3/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK WEAVER JR.</u>		22d. ADDRESS <u>LAUREL, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-20-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cem. Laurel Md.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>de Witt Canale dean Laurel Md</u>		25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

35010

03020

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G387 3/28/67 pc

04038

CERTIFICATE OF DEATH

04037

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANHAM</u>		c. LENGTH OF STAY IN lb <u>2 mos</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MAGNOLIA GARDENS Nsg. HOME</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EAST RIVERDALE</u> 16-1	
3. NAME OF DECEASED (Type or print) <u>Dorothy DeGraffenried</u>		d. STREET ADDRESS <u>5607 - 62ND AVE</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>CAUC.</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH <u>MARCH 17 1967</u>	
9. AGE (In years last birthday) <u>77 7/16</u> YRS.		IF UNDER 1 YEAR: Months <u>16</u> Days <u>17</u> Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>LAFAYETTE KNAPP</u>		14. MOTHER'S MAIDEN NAME <u>IDA ROME</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-09-9177-D</u>	
17. INFORMANT <u>GAYLE NASH, R.N.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>7824</u> IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/14</u> , 19 <u>67</u> , to <u>3/17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/17</u> , 19 <u>67</u> , and that death occurred at <u>6:05</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Leon Levitsky</u>		22b. DATE SIGNED <u>3/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>LEON LEVITSKY, M.D.</u>		22d. ADDRESS <u>MT RAINIER, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>3/20/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LEE'S CREMATORY</u>		23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON D.C.</u>	
24. FUNERAL DIRECTOR <u>LEE FUNERAL HOME</u> ADDRESS <u>3004 V. ST. WASH, DC.</u>		25a. REC'D BY REGISTRAR <u>MAR 22 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

00000

00000

MAR 2 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04039					04038				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)				
a. COUNTY PRINCE GEORGES MARYLAND					a. STATE MARYLAND b. COUNTY PRINCE GEORGES				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON				
c. LENGTH OF STAY IN 1b					d. STREET ADDRESS 8728 SURRATTS ROAD				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SOUTHERN MEDICAL CENTER, CLINTON, Md.					a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last JANET ELIZABETH DIXON					Month Day Year MARCH 1 19 67				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEBRUARY 14, 1914		9. AGE (In years last birthday) 53 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME JOHN M. COY					14. MOTHER'S MAIDEN NAME CLARA M. DIEHL				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO					16. SOCIAL SECURITY NO. BERYL M. DIXON				
17. INFORMANT SAME AS # 2					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> 4201 DUE TO <i>Coronary Occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <i>1963</i> to <i>March 1, 1967</i> that (I) (we) last saw the deceased alive on <i>March 1, 1967</i> , and that death occurred at <i>11:00 A.M.</i> from the causes and on the date stated above.									
22a. SIGNATURE <i>Robert E. Peterson</i> M.D.									
22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) ROBERT E. PETERSON									
22d. ADDRESS 6106 OLD SILVER HILL RD A D									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL									
23b. DATE THEREOF MARCH 4, 1967									
23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY									
23d. LOCATION (City, town or county) (State) PRINCE GEORGES, MARYLAND									
24 FUNERAL DIRECTOR'S SIGNATURE ROBERT E. ADDRESS MARYLAND WILHELM FUNERAL HOME 4308 SUTLAND RD. SUTLAND									
25a. REC'D BY REGISTRAR DATE MAR 6 1967									
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									

04038

04038

DETROIT

1967

1967

1967

MAR 8 1967

1967

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04040

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04039

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			c. LENGTH OF STAY IN 1b DOA		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chamber's Funeral Home			d. STREET ADDRESS 7903 82nd. Avenue		
3. NAME OF DECEASED (Type or print) First Durald Middle F. Last Dodd			4. DATE OF DEATH Month 3 Day 7 Year 19 67		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-11-1922	9. AGE (In years last birthday) 45 yrs.	10. IF UNDER 1 YEAR Months 7 Days 19 Hours 67 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY GOETZ MEAT CO.		11. BIRTHPLACE (State or foreign country) ALABAMA	
13. FATHER'S NAME LEE F. DODD			14. MOTHER'S MAIDEN NAME MARY TINGLE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES W.W. II		16. SOCIAL SECURITY NO. 418-18-5722		17. INFORMANT EDNA FULLER DODD Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of head DUE TO (b) 976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self thru mouth with 30 Cal. rifle.			
20c. TIME OF INJURY Month, Day, Year about 1:00pm 3-7- 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work x bedroom of home		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) same as #2	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 3-8-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 11 MAR 1967	23c. NAME OF CEMETERY OR CREMATORY WINSTON MEM CEM.	23d. LOCATION (City or Town) (County) (State) HALEYVILLE ALABAMA	25a. RECD BY REGISTRAR Mar 10 1967	
24. FUNERAL DIRECTOR W.W. Chambers Co., Riverdale, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge			

01032

00000

George Washington

Washington

George Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04041

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04040

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b DOA			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier d. STREET ADDRESS 4203 Russell Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Howard Luther Dove			4. DATE OF DEATH Month Day Year 3 30 67		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-25-1894		9. AGE (In years lost birthday) yrs. 72
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY D.C. Transcit		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Joseph Smith		
14. MOTHER'S MAIDEN NAME Unknown			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO. 578-10-8410			17. INFORMANT Mrs. Sadie F. Dove (above address) Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH minutes unknown					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes - over 5 yrs					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED 3-31-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/1/67		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.	
23d. LOCATION (City or Town) Colmar Manor, Md.		(County)		(State)	
24. FUNERAL DIRECTOR Funeral Home's Inc.		ADDRESS Maryland Rainier,		25a. REC'D BY REGISTRAR APR 3 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge					

04020

04020

George George's

George George's

George George's

George George's

George George's

George George's

George George's

George George's

George George's

George George's

George George's

George George's

George George's

George George's

George George's

George George's

George George's

George George's

George George's

George George's

George George's

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

DIVISION
04042

Item #9 Film #0355 3/29/07

04041

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived, If institution- residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		b. COUNTY Prince Georges	
c. LENGTH OF STAY IN lb 3 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bowie	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 12702 Beaverdale Lane	
3. NAME OF DECEASED (Type or print) Edna W. Dunaway		4. DATE OF DEATH Month March Day 13 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 Sept., 1928
9. AGE (In years last birthday) 38 39/ yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George A. Whitely		14. MOTHER'S MAIDEN NAME Jeanette Balian	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-22-6198	
17. INFORMANT Mr. Carl W. Dunaway (above address)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism & Pul. Infarction 163X DUE TO Left lower lobe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary carcinoma Lt. upper lobe - 9 mos. DUE TO 4 metastases to Brain Lt side & post horn (c) were Lt & Rt side 6 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulm. Pulmonary edema			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY , 1966, to MARCH 13 , 1967, that (I) (we) last saw the deceased alive on MARCH 13 , 1967, and that death occurred at 11:30 PM from the causes and on the date stated above.			
22a. SIGNATURE Norman K. Bohrer		22b. DATE SIGNED March 14, 1967	
22c. PHYSICIAN'S NAME (Type) Norman K. Bohrer, M.D.		22d. ADDRESS 3231 Superior Lane, Bowie, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 3/16/67	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR Valley's Funeral Home Inc.		25a. REC'D BY REGISTRAR MAR 17 1967	
ADDRESS 1111 Rainier Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

000001

Prince Georges

Boyle

Boyle

Boyle

Boyle

Boyle

Boyle

Boyle

Boyle

Boyle

Boyle

Boyle

Boyle

Boyle

Boyle

Boyle

Boyle

Boyle

Boyle

Boyle

Boyle

Boyle

Boyle

Boyle

Boyle

Boyle

Boyle

Boyle

Boyle

Boyle

Boyle

Boyle

Boyle

VR A15 (4)
25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that Page 4 may be retained by the hospital or attending physician.

00000

OFFICIAL OF DEATH

00000

Prince Georges

Married

Prince Georges

17th 12th 1899

Georgy

1899 1899

Prince Georges General Hospital

Married 1899

Prince

Prince

Prince

1899 1899

1899

1899

1899

1899 1899

1899 1899

1899 1899

1899 1899

1899 1899

1899 1899

1899 1899

1899 1899

1899 1899

1899 1899

1899 1899

1899 1899

1899 1899

FOR STATE
HEALTH DEPT.

04044

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04043

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor 161	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital			d. STREET ADDRESS 3616 40th. Place		
3. NAME OF DECEASED (Type or print) First Norman Middle Edwards Last Edwards			4. DATE OF DEATH Month 3 Day 21 Year 19 67		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 Jan. 1938		9. AGE (In years lost birthday) 29 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY Express Co		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Norman L. Edwards			14. MOTHER'S MAIDEN NAME Lucy V Nevitt		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes		16. SOCIAL SECURITY NO. 220 34 4673		17. INFORMANT Linda D Edwards Address Hillcrest Heights, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 8234 IMMEDIATE CAUSE (a) Laceration of brain DUE TO Fracture of skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in car which went out of control and hit a tree.			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 4:49am 3-21- 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5300 block Riverdale Rd., Riverdale, Md.	
20f. (City or town) (County) (State) Riverdale, Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 3-21-67		22. DATE SIGNED 3-21-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 24, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	
23d. LOCATION (City or Town) (County) (State) Colmar Manor, Pro Geo Md.		24. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE MAR 28 1967	
25b. REGISTRAR'S SIGNATURE J Charles Judge					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

64020

22020

CERTIFICATE OF DEATH

Reg. Dist. No. 04044

04045

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4914 Porter Ave.</u>		d. STREET ADDRESS <u>4914 Porter Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ellen</u> Last <u>EMMONS</u>		4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 14, 1868</u>
9. AGE (In years last birthday) yrs. <u>98</u>		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S. of Am.</u>
---	--	--	--

13. FATHER'S NAME <u>UNKNOWN</u> <u>Mrs. Hagen</u>	14. MOTHER'S MAIDEN NAME <u>Margaret Wood</u>
---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>220-46-4485</u>	17. INFORMANT <u>Mrs. Thelma L. McGuire</u>	Address <u>4914 Porter Ave. Suitland, Md.</u>
--	---	--	---

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> 443K DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Uremia with resultant Anemia</u> DUE TO (c) <u>Hypertensive Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>7 months</u>
--	--	---

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
---	--	---

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u> 19 <u>—</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>April 6, 1965</u> , to <u>March 6, 1967</u> , that I last saw the deceased alive on <u>March 5, 1967</u> , and that death occurred at <u>9:45</u> AM, from the causes and on the date stated above.	
--	--

ACTUAL SIGNATURE <u>Walcutt W. Gibson</u> M.D.	ADDRESS (Street, city or town, state) <u>4300 St. Barnabas Road</u>	DATE SIGNED <u>March 6, 1967</u>
PHYSICIAN'S NAME (Type) <u>Walcutt W. GIBSON</u>	<u>Marlow Heights, Maryland 20031</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 9, 1967</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges, Maryland</u>
--	---	--	--

23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Wilhelm</u>	ADDRESS <u>Suitland, Md.</u>	24a. REC'D BY REGISTRAR <u>MAR 13 1967</u>	24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
--	---------------------------------	---	--

10-15
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04046

CERTIFICATE OF DEATH

04045

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Louis H English		4. DATE OF DEATH Month Day Year March 16 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 Oct. 1918
9. AGE (In years last birthday) 48 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Industrial Spec.	
11. BIRTHPLACE (County & State, or foreign country) La.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George L. English		14. MOTHER'S MAIDEN NAME Caffie L. Napper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Helen J. English		Address Same as # 2 (Wife)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary thrombosis DUE TO (c) Coronary atherosclerosis			INTERVAL BETWEEN ONSET AND DEATH 7-9 days 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 14, 19 67 to March 16, 19 67 , that (I) (we) last saw the deceased alive on March 16, 19 67 , and that death occurred at 5:47 AM , from causes and on the date stated above.			
22a. SIGNATURE Bernard J. Walsh		22b. DATE SIGNED 3/16/67	
22c. PHYSICIAN'S NAME (Type) Bernard J. Walsh, M.D.		22d. ADDRESS 1800 Eye St., N.W. Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/19/67	23c. NAME OF CEMETERY OR CREMATORY Harmony Chapel Cemetery	23d. LOCATION (City or Town) (County) (State) Bubach La.
24. FUNERAL DIRECTOR F. Gasch'S Sons		25a. REC'D BY REGISTRAR MAR 17 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04045

04045

04045

Prince Georges

Prince Georges

Prince Georges

Hyattsville

Hyattsville

Hyattsville

Hyattsville

Hyattsville

Hyattsville

Hyattsville

Hyattsville

Hyattsville

Hyattsville

Hyattsville

Hyattsville

Hyattsville

Hyattsville

Hyattsville

Hyattsville

Hyattsville

Hyattsville

Hyattsville

Hyattsville

Hyattsville

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04047

CERTIFICATE OF DEATH

04046

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE			c. LENGTH OF STAY IN 1b 56 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS				d. STREET ADDRESS 8307 RANNER DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HAROLD Middle JAY Last ESHLEMAN				4. DATE OF DEATH Month MARCH Day 13 Year 19 67			
5. SEX MALE		6. COLOR OR RACE CAU		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2 MARCH 1928	
9. AGE (In years last birthday) 39 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MSGT - ENLISTED		10b. KIND OF BUSINESS OR INDUSTRY U.S. AIRFORCE		11. BIRTHPLACE (County & State, or foreign country) ELIZABETHTOWN, PA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME IRA WILLIAM ESHLEMAN			
14. MOTHER'S MAIDEN NAME VIRGIE ESTHER RISSE				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES SEP 46 - PRESENT			
16. SOCIAL SECURITY NO. 197-20-1791				17. INFORMANT GERALDINE H. ESHLEMAN (WIFE) Address SAME AS # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE DUE TO RESPIRATORY FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) STAGE IV, HODGKIN'S DISEASE (c) STAGE IV, HODGKIN'S DISEASE							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (4) (this hospital) attended the deceased from 26 JAN 19 67 , to 13 MARCH 1967 , that (1) (we) last saw the deceased alive on 23 MARCH 19 67 , and that death occurred at 0302 M , from causes and on the date stated above.			
22a. SIGNATURE <i>Frederick Sachs</i> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 13 MARCH 1967	
22c. PHYSICIAN'S NAME (Type) FREDERICK SACHS, CAPT, USAF, MC				22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASH, D.C. 20331			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 3/16/67		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATL.		23d. LOCATION (City or Town) (County) (State) ARLINGTON VA.	
24. FUNERAL DIRECTOR W.W. CHAMBERS CO. INC				25a. REC'D BY REGISTRAR WASH. D.C.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

04048

UNITED STATES DEPARTMENT OF AGRICULTURE

04048

JAN 1 1961

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04048

CERTIFICATE OF DEATH

04047

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN TB 6 6 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 9707 Rhode Island Ave.			
3. NAME OF DECEASED (Type or print) First Bertha Middle MARIE Last Ewell				4. DATE OF DEATH Month March Day 5 Year 1967			
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-14-20		9. AGE (In years lost birthday) 46 yrs.		10. IF UNDER 1 YEAR Months 4 Days 6 Hours 17 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Washington DC		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Olin Layton				14. MOTHER'S MAIDEN NAME Sara C. Cahill			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT JAMES R. EWELL.		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory failure DUE TO cerebral edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) glioma of brain (c) gastrointestinal hemorrhage							INTERVAL BETWEEN ONSET AND DEATH 2 days 1 month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) gastrointestinal hemorrhage							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 2-27 , 1967 , to 3-5 , 1967 , that (I) (we) last saw the deceased alive on 3-4 , 1967 , and that death occurred at 3-5 , 1967 , from causes and on the date stated above.							
22a. SIGNATURE Ruth Kerr Jakoby M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Mar-6-67	
22c. PHYSICIAN'S NAME (Type) Ruth Kerr Jakoby				22d. ADDRESS 6408 Landover Rd			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9 MARCH 1967		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM		23d. LOCATION (City or Town) (County) (State) SOUTLAND, MARYLAND	
24. FUNERAL DIRECTOR W.W. CHAMBERS Co.				ADDRESS RIVERDALE, MD.		25a. REC'D BY REGISTRAR DATE MAR 8 1967	
				25b. REGISTRAR'S SIGNATURE J Charles Judge			

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04043

CERTIFICATE OF DEATH

04048

1. PLACE OF DEATH a. COUNTY <u>Prince Geo</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Beltzville</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltzville</u>		c. LENGTH OF STAY IN 1b <u>6 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Paint Branch Nursing Home</u>		d. STREET ADDRESS <u>3120 Powdermill Rd</u>	
3. NAME OF DECEASED (Type or print) <u>BERTHA</u> First Middle Last		4. DATE OF DEATH <u>3</u> <u>26</u> <u>1967</u> Month Day Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-18-87</u> 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Franklin Rabbin</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u> Sara Estes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>446-07-1939</u>	
17. INFORMANT <u>Mr. L. Leuz</u>		Address <u>4716 Brandon Lane</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>1539</u> IMMEDIATE CAUSE (a) <u>Generalized Carcinoma Toxic</u> DUE TO (b) <u>Carcinoma of Bowel</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> <u>4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondary anemia from hemorrhage</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II or item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>—</u> , 19 <u>58</u> , to <u>3-26</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) lost the deceased alive on <u>3-22</u> , 19 <u>67</u> , and that death occurred at <u>2P</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>R.D. Bauer MD</u>		22b. DATE SIGNED <u>3-26-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R.D. Bauer MD</u>		22d. ADDRESS <u>2513 Buckhugard Rd. Adelphi, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>30 Nov 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>DRUMRIGHT, CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>DRUMRIGHT, OKLAHOMA</u>
24. FUNERAL DIRECTOR <u>Generali Funeral Home</u>		25a. REC'D BY REGISTRAR <u>WASH DC</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>MAR 29 1967</u>	

84050

84050

et al.

et al.

Conservation of Forest

Conservation of Forest

K. D. Bower, M.D.
K. D. Bower, M.D.

3-27-82
3-27-82
3-27-82

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04050

CERTIFICATE OF DEATH

04049

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN TB 1 DAY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY PRINCE GEORGES		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DISTRICT HEIGHTS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) US AIR FORCE HOSPITAL ANDREWS						d. STREET ADDRESS 5821 MARLBORO RD, APT 301						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN ANTHONY GALLICE						4. DATE OF DEATH Month MARCH Day 16 Year 19 67							
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 14 MARCH 1967		9. AGE (In years last birthday) yrs. 1		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA				10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (County & State, or foreign country) PRINCE GEORGE'S, MD.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME JOHN JOSEPH GALLICE, JR						14. MOTHER'S MAIDEN NAME ANNA MAE HORWAT							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NA		17. INFORMANT FATHER		Address SAME AS ITEM #2							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO 7545 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CONGESTIVE HEART FAILURE DUE TO (c) CONGENITAL HEART DISEASE										INTERVAL BETWEEN ONSET AND DEATH 1 DAY 1 DAY 1 DAY			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)					
21. I certify that this (this hospital) attended the deceased from 14 March, 1967 , to 16 March, 1967 , that (s) (we) last saw the deceased alive on 16 March 19 67 , and that death occurred at 510A AM, from causes and on the date stated above.													
22a. SIGNATURE <i>Michael L. Jordan</i>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 16 Mar 1967					
22c. PHYSICIAN'S NAME (Type) MICHAEL L. JORDAN CAPT USAF MC						22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB WASH DC 20331							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 3/20/67		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY ARLINGTON, VIRGINIA				23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR ROBERT E WILHELM FUNERAL HOME 4308 SUITLAND ROAD, SUITLAND, MARYLAND						25a. REC'D BY REGISTRAR DATE MAR 20 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

7-226612

04042

FRUITFUL B. DEATH

04042

FRUITFUL B. DEATH

FRUITFUL B. DEATH

FRUITFUL B. DEATH

FRUITFUL B. DEATH

FRUITFUL B. DEATH

FRUITFUL B. DEATH

FRUITFUL B. DEATH

FRUITFUL B. DEATH

FRUITFUL B. DEATH

FRUITFUL B. DEATH

FRUITFUL B. DEATH

FRUITFUL B. DEATH

FRUITFUL B. DEATH

FRUITFUL B. DEATH

FRUITFUL B. DEATH

FRUITFUL B. DEATH

FRUITFUL B. DEATH

FRUITFUL B. DEATH

FRUITFUL B. DEATH

FRUITFUL B. DEATH

FRUITFUL B. DEATH

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05612

05612

1. PLACE OF DEATH o. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY in 1b 10 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PrinceGeorges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY PrinceGeorges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton d. STREET ADDRESS Steed Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Robert Eli Garner		4. DATE OF DEATH Month Day Year March 19 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 Sept., 1878
9. AGE (In years lost birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 16.1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farming		10b. KIND OF BUSINESS OR INDUSTRY Tenent	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Benjamin Robert Garner		14. MOTHER'S MAIDEN NAME Mary Zora Rawlings	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Bertie Virginia Garner- #2		Address Same as Item	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Pulmonary Edema, Bilat DUE TO 199.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CANCE of Ext + lat. auditory canal w/ DUE TO metastasis to lungs and		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) acute Bilat Pyelonephritis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from March 9, 1967 , to March 19, 1967 , that (I) (we) last saw the deceased alive on March 19, 1967 , and that death occurred at 5:30AM from causes and on the date stated above.			
22a. SIGNATURE Edwin J. Jensen		22b. DATE SIGNED 3/20/67	
22c. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M. D.		22d. ADDRESS Pr. Geo General Hospital, Cheverly, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/22/67	23c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery	23d. LOCATION (City or Town) (County) (State) Forestville, Md.
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.		25a. REC'D BY REGISTRAR APR 12 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05615

05615

Princeton, New Jersey
 10 days
 Princeton, New Jersey
 10 days

Princeton, New Jersey
 10 days
 Princeton, New Jersey
 10 days

Princeton, New Jersey
 10 days
 Princeton, New Jersey
 10 days
 Princeton, New Jersey
 10 days

Princeton, New Jersey
 10 days
 Princeton, New Jersey
 10 days
 Princeton, New Jersey
 10 days
 Princeton, New Jersey
 10 days

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04051

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04050

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aquasco 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d. STREET ADDRESS Box 23, Rt. 1, Aquasco Neck Rd.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last George Cardinal Gibbons			4. DATE OF DEATH Month Day Year 3 22 19 67		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-21-1898		9. AGE (In years last birthday) 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Tobacco		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME William Lloyd Gibbons		
14. MOTHER'S MAIDEN NAME Price Susanna DeMarr			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO. 213-38-3257			17. INFORMANT Edith Gibbons, Aquasco, Md. 20608		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH minutes over 3 yrs.					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe		M.D. John Kehoe, M.D.		22. DATE SIGNED 3-23-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		RIVERDALE, MD.		23. DATE SIGNED 3-23-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-25-67		23c. NAME OF CEMETERY OR CREMATORY St Marys Cemetery	
23d. LOCATION (City or Town) Aquasco, P.G., Md.		23e. LOCATION (County) P.G.		23f. LOCATION (State) Md.	
24. FUNERAL DIRECTOR The Hunt Funeral Home, Waldorf, Md.		ADDRESS Waldorf, Md.		25. REGD BY REGISTRAR MAR 27 1967	
25a. REGISTRAR'S SIGNATURE J. Charles Judge		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

04050

04051

John, George

Bartholomew

John, George

Bartholomew

John

Bartholomew

Box 1, St. I. Avenue, Wash. D.C.

Bartholomew, George

Bartholomew

Bartholomew

Bartholomew

Box 1, St. I. Avenue, Wash. D.C.

Bartholomew, George

Bartholomew, George

Bartholomew

Bartholomew

Bartholomew, George

Bartholomew, George

Box 1, St. I. Avenue, Wash. D.C.

Bartholomew, George

Bartholomew

Bartholomew

Bartholomew

Box 1, St. I. Avenue, Wash. D.C.

Bartholomew, George

Box 1, St. I. Avenue, Wash. D.C.

Bartholomew, George

Bartholomew, George

Box 1, St. I. Avenue, Wash. D.C.

Box 1, St. I. Avenue, Wash. D.C.

Bartholomew, George

Box 1, St. I. Avenue, Wash. D.C.

Bartholomew, George

Bartholomew, George

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04052

CERTIFICATE OF DEATH

04051

1. PLACE OF DEATH a. COUNTY <u>PR. GEORGE'S</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. GEORGE'S</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PINE VIEW GARDENS CARE CTR</u>		d. STREET ADDRESS <u>191-89th AVE, LANDOVER MD</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELLA E GIBSON</u>		4. DATE OF DEATH Month Day Year <u>MARCH 30 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>1/1/99</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>RED SPRING, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.D.</u>	
13. FATHER'S NAME <u>WILL MCNEEL</u>		14. MOTHER'S MAIDEN NAME <u>ANN CAMPBELL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Cardiovascular disease</u> DUE TO (c) <u>Arteriosclerosis advanced</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>3-5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-1</u> , 19 <u>67</u> , to <u>3-30</u> , 19 <u>67</u> that (II) (we) last saw the deceased alive on <u>3-30</u> , 19 <u>67</u> , and that death occurred at <u>8:32</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred R. Lapin M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, M.D.</u>		22d. ADDRESS <u>PINE VIEW GARDENS, CLINTON, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 3rd 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Harmony Mem. Park</u>	23d. LOCATION (City or Town) (County) (State) <u>7601- Sheriff Rd. Maryland</u>
24. FUNERAL DIRECTOR <u>Washington Funeral Chapel</u>		25a. REC'D BY REGISTRAR <u>APR 7 1967</u>	
ADDRESS <u>475- H St. N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

04021

OFFICE OF THE

04025

RECEIVED
JUN 10 1964

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

MEMORANDUM FOR THE DIRECTOR
SUBJECT: [Illegible]

[Illegible text in the main body of the document]

100-100000-1000

100

100

100

100

100

100

100

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04053

04052

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel 167	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6 Laurel Manor Court		d. STREET ADDRESS 6 Laurel Manor Court	
3. NAME OF DECEASED (Type or print) Florentine Maude Gilbert		4. DATE OF DEATH 3 9 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 July 1889
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Household		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Farmington, MAINE		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME CHARLES E. KEITH		14. MOTHER'S MAIDEN NAME JENNIE METCALF	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 161-12-7014	
17. INFORMANT MR HERBERT C GILBERT, LAUREL, MD		Address 1065 5th St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Heart failure DUE TO Hypertensive cardio vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH minutes over 10 yrs.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 3-10-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION MAR. 11, 1967		23b. DATE THEREOF 77 LINCOLN CEMETERY WASH. D.C.	
23c. NAME OF CEMETERY OR CREMATORY Harold S. WAOE, LAUREL, MARYLAND		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Harold S. WAOE, LAUREL, MARYLAND		25a. READ BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAR 14 1967	

04025

04025

George's George's

Jan 2 1952

George's George's

George's

George's George's

George's George's

George's George's

George's George's

George's George's

George's George's

George's George's

MAR 1 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04054

CERTIFICATE OF DEATH

04053

1. PLACE OF DEATH a. COUNTY P.G. County Riverdale <small>MARYLAND</small>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY P.G.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Md.		c. LENGTH OF STAY IN 1b 1 Day-	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville, Md.		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 73 Eugene Leland Hospital		d. STREET ADDRESS 11338 Cherry Hill, Rd,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Goldberg, Mrs. Sarah,		4. DATE OF DEATH Month 3- Day 19 Year 19 67	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-15-88	
9. AGE (In years lost, birthday) 78 yrs.		IF UNDER 1 YEAR Months 7 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? Amer	
13. FATHER'S NAME Bernhard Finkelstine,		14. MOTHER'S MAIDEN NAME Cecilia Roeschman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Eugene Leland Hospital,		Address 4408 Queensbury Drive	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) General arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH undetermined	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from mar 18, 1967 to mar 19, 1967 , that (I) (we) last saw the deceased alive on mar 19, 1967 , and that death occurred at 12 PM , from causes and on the date stated above.			
22a. SIGNATURE L.W. Malin		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) L.W. MALIN M.D.		22d. ADDRESS Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-22-67	
23c. NAME OF CEMETERY OR CREMATORY King David Memorial Garden Falls Church, Va.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Bernard Danzansky & Sons Washington DC		25a. REC'D BY REGISTRAR MAR 23 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

05053

OFFICE OF HEALTH

05053

1.0.

1.0.

1.0.

1.0.

1.0.

1.0.

1.0.

1.0.

1.0.

1.0.

1.0.

1.0.

1.0.

1.0.

1.0.

1.0.

1.0.

1.0.

1.0.

1.0.

1.0.

1.0.

1.0.

1.0.

1.0.

1.0.

1.0.

1.0.



Department of Health
Bureau of Health Statistics
1.0.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04055

04054

FOR STATE
HEALTH DEPT. M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				d. STREET ADDRESS 830 Cox Avenue			
3. NAME OF DECEASED (Type or print) Ralph Franklin Gordon Sr.				4. DATE OF DEATH Month 3 Day 21 Year 19 67			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11 April 1909 57 yrs.	
9. AGE (In years lost birthday) 57		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired D C Fireman		10b. KIND OF BUSINESS OR INDUSTRY D C Government		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME William F Gordon			
14. MOTHER'S MAIDEN NAME Fannie Potter				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, of unknown) (If yes give war or dates of service) no			
16. SOCIAL SECURITY NO. 578 10 5480				17. INFORMANT Ruth L. Gordon Address Chillum, Maryland.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease over 10 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aleukemic leukemia - over 3 months.							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D.				22. DATE SIGNED 3-22-67			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Type) Burial		23b. DATE THEREOF Mar 24, 1967		23c. NAME OF CEMETERY OR CREMATORY Salem Cemetery		23d. LOCATION (City or Town) (County) (State) Winston Salem North Carolina	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE MAR 28 1967							

04054

04055

4)

since because

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04056

04055

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park 16-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9223 B altimore Avenue				d. STREET ADDRESS 9223 Baltimore Avenue			
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Bernard Graf				4. DATE OF DEATH Month Day Year March 3 19 67			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 15, 1894	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Gift shop		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Bernard Graf				14. MOTHER'S MAIDEN NAME Oglesby			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 269 12 7238		17. INFORMANT Blanche E Graf		Address College Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive polmonary embolus DUE TO Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause last. (b) Phlebo-thrombosis of right femoral vein DUE TO (c) Immobilization of leg in cast							INTERVAL BETWEEN ONSET AND DEATH minutes over 24 hrs 7 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell, in hotel room.					
20c. TIME OF INJURY Month, Day, Year 9:30AM 1-14-67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, etc.) Penn-Sheraton Hotel		20f. (City or town) (County) (State) Pittsburg Pa.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (City or town) (County) (State) Riverdale, Md.		22. DATE SIGNED 3-4-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 7, 1967		23c. NAME OF CEMETERY OR PLACE Rose Hill Burial Park		23d. LOCATION (City or Town) (County) (State) Akron Summit Ohio	
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE MAR 7 1967	
				25b. REGISTERING SIGNATURE John Charles Judge			

MEDICAL CERTIFICATION

04052

04052

Prime George's

Prime George's

Prime George's

Prime George's

Prime George's

Prime George's

Prime George's

Prime George's

Prime George's

Prime George's

Prime George's

Prime George's

Prime George's

Prime George's

Prime George's

Prime George's

Prime George's

Prime George's

Prime George's

Prime George's

Prime George's

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04057

04056

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5419 Quintana Street		d. STREET ADDRESS 5419 Quintana Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Arthur F. Granholm First Middle Last		4. DATE OF DEATH Month Day Year March 17, 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 12, 1891
9. AGE (In years past birthday) yrs. 75		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (County & State, or foreign country) New Jersey
12. CITIZEN OF WHAT COUNTRY U S A		13. FATHER'S NAME Charles F Granholm	
14. MOTHER'S MAIDEN NAME Josephine -		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 718 14 9966		17. INFORMANT Edna N Granholm Address Riverdale, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 4222 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH 5 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1958 to 3-17, 1967 that (I) (we) last saw the deceased alive on 3-17, 1967 , and that death occurred at 11 P M, from causes and on the date stated above.			
22a. SIGNATURE Leonard Hays		22b. DATE SIGNED 3-18-67	
22c. PHYSICIAN'S NAME (Type) Leonard Hays		22d. ADDRESS Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Mar 21, 1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland Pr Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR MAR 20 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

04052

04052

04052

100.000

100.000

100.000

100.000

100.000

100.000

100.000

100.000

100.000

100.000

100.000

100.000

100.000

100.000

100.000

100.000

100.000

100.000

100.000

100.000

100.000

100.000

100.000

100.000

100.000

100.000

100.000

100.000

100.000

100.000

100.000

VR A15 (4)
20 M 1/66

04052

OFFICE OF THE

04052

11

x

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04059

CERTIFICATE OF DEATH

04058

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE N. J. b. COUNTY J	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN TB 24 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Montclair	
3. NAME OF DECEASED (Type or print) First Willie Middle Mae Last Gray		4. DATE OF DEATH Month 3 Day 11 Year 19 67	
5. SEX F	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/2/1909
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State, or foreign country) S. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Matthew Ackinson		14. MOTHER'S MAIDEN NAME Cora Bowlin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-30-9738	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident, probably hemorrhage DUE TO (b) 331X DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic heart disease; diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 2/15/ , 19 67 , to 3/11/ , 19 67 , that (we) lost the deceased alive on 3/11/ , 19 67 , and that death occurred at 1:55AM , from causes on and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 3/11/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) 3/15/67		23b. DATE THEREOF Heaven Rest	
23c. NAME OF CEMETERY OR CREMATORY Heaven Rest		23d. LOCATION (City or Town) (County) (State) Manover N.J.	
24. FUNERAL DIRECTOR For: BROOKS & Allen		25. RECEIVED BY REGISTRY 3-13-67	

04058

04058

W. J. L.

Prince George

Montclair

24 days

Glen Dale (total)

10 Newton Street

Glen Dale Hospital

07

11

2

Gray

1906

Willie

24

12/1/09

8

11

7

1904

S. C.

1

unemployed

Cora Foster

Martha Robinson

Deceased

577-30-0738

No

11 Nov

11 Nov

11 Nov

11 Nov

11 Nov

11 Nov

11 Nov

11 Nov

11 Nov

11 Nov

11 Nov

Glen Dale Hospital

Glen Dale, Md.

Mr. Walter H. D.

11 Nov

11 Nov

FOR STATE
HEALTH/DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04060

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04059

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN 1b 16-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4203 Braxton Place				d. STREET ADDRESS 4203 Braxton Place			
3. NAME OF DECEASED (Type or print) William Green				4. DATE OF DEATH Month 3 Day 29 Year 19 67			
5. SEX male	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 Feb. 1884		9. AGE (In years lost birthday) 83 yrs.	10. IF UNDER 1 YEAR Months 0 Days 29 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labia		10b. KIND OF BUSINESS OR INDUSTRY Florist		11. BIRTHPLACE (State or foreign country) the Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Green				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Betha Matthews		Address Glen Baden Rd 8620 Johnson Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 144X Metastatic carcinoma DUE TO Epidermoid carcinoma of palate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH over 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 3-30-67		22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 4-3-67		23c. NAME OF CEMETERY OR CREMATORY Nat Harmony		23d. LOCATION (City or Town) (County) (State) Highland Park Md	
24. FUNERAL DIRECTOR W S Washington & Sons 4925 Deane Ave NE				25a. REC'D BY REGISTRAR APR 4 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

04029

04029

since 1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04061

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04060

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pro Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.		c. LENGTH OF STAY IN 1b D O A	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt, Md.		16.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 9210 Springhill Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Tori Allen Grossman		4. DATE OF DEATH Month March Day 18 , Year 67 .	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 Aprl. 1963
9. AGE (In years last birthday) 3 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Thomas Grossman		14. MOTHER'S MAIDEN NAME Carolyn R. Wieser	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Father		Address Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 9294 IMMEDIATE CAUSE (a) DROWNING DROWNING DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____		INTERVAL BETWEEN ONSET AND DEATH Few Min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Subject fell in swimming pool	
20c. TIME OF INJURY Month, Day, Year 5:00 Hour a.m. 3/18 19 67 p.m.		20d. INJURY OCCURRED 2 While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Swimming Pool		20f. (City or town) (County) (State) Greenbelt Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dayton O Watkins M.D. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED 3/19/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 23 Mar 67	
23c. NAME OF CEMETERY OR REPOSITORY Flushing Cemetery		23d. LOCATION (City or Town) (County) (State) Flushing New York	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR MAR 23 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

00000

00000

THE NEW YORK PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATION
500 5th Ave. New York 17, N.Y.

RECEIVED

LIBRARY

NEW YORK

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

2 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04062

CERTIFICATE OF DEATH

04061

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 2506 Clark Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Naomi F Haga		4. DATE OF DEATH Month Day Year March 14 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 Aug., 1907
9. AGE (In years lost birthday) yrs. 59		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (County & State, or foreign country) Potts Creek, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Wm. Oyler		14. MOTHER'S MAIDEN NAME Fannie Catherine Tucker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Ray Haga, Laurel, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure DOE-TO (b) RT coronary thrombosis DUE-TO (c) Brain pulmonary edema			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 3, 1967 to March 14, 1967 , that (I) (we) last saw the deceased alive on March 14, 1967 , and that death occurred at 6:20 PM , from causes and on the date stated above.			
22a. SIGNATURE Edwin J. Jensen		22b. DATE SIGNED March 15, 1967	
22c. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M.D.		22d. ADDRESS Prince Georges General Hospital, Cheverly	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried	23b. DATE THEREOF 3-17-67	23c. NAME OF CEMETERY OR CREMATORY Union Cemetery	23d. LOCATION (City or Town) (County) (State) Burtonville, Md.
24. FUNERAL DIRECTOR De Witt Donaldson		25a. REC'D BY REGISTRAR MAR 20 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02002

02001

Trinity Hospital

Trinity Hospital

Trinity Hospital

Trinity Hospital

Trinity Hospital

Trinity Hospital

Trinity Hospital

Trinity Hospital

Trinity Hospital

Trinity Hospital

Trinity Hospital

Trinity Hospital

Trinity Hospital

Trinity Hospital

Trinity Hospital

04063

04062

Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

04083

04083

Prince George's

Island

Island

Island

Island

Island

Prince George's Island

Island

Island

Island

Island

Island

Island

Island

Island

Island

Island

Island

Island

Island

Island

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #11 & 12 Film #G386 3/16/67 pc

04064

CERTIFICATE OF DEATH

04063

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 20 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville		116-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 11266 Evans Trail	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edwin Middle Hamilton Last Hamilton		4. DATE OF DEATH Month March Day 7 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 Aug., 1899
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Remington, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hugh Hamilton		14. MOTHER'S MAIDEN NAME Mary Clementine Slaughter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 11		16. SOCIAL SECURITY NO. 119-07-2185	
17. INFORMANT Mrs. Elsie V. Hamilton, Beltsville, Md.		Address 11266 Evans Trail	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO (b) Anteromedullary Heat Stroke DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-15, 1967, to 3-7, 1967, that (I) (we) last saw the deceased alive on 3-6, 1967, and that death occurred at 6:50 AM, from causes and on the date stated above.			
22a. SIGNATURE Dr. A. Deitz		22b. DATE SIGNED 3-7-67	
22c. PHYSICIAN'S NAME (Type) Dr. A. Deitz, M.D.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 8, 1967	
23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		23d. LOCATION (City or Town) (County) (State) Richmond, Virginia	
24. FUNERAL DIRECTOR Ives Funeral Home		ADDRESS Arlington, Virginia	
25a. REC'D BY REGISTRAR MAR 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

04004

MINISTRY OF OCEAN

04004

04004

04004

04004

04004

04004

04004

04004

04004

04004

04004

04004

04004

04004

04004

04004

04004

04004

04004

04004

04004

04004

04004

04004

04004

04004

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05630

05630

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS Box 2375 Leland Rd., South	
3. NAME OF DECEASED (Type or print) First Benjamin Middle Hardesty Last Hardesty		4. DATE OF DEATH Month 3 Day 25 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 May 1893
9. AGE (In years lost birthdate) 73 yrs.		10. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farming		10b. KIND OF BUSINESS OR INDUSTRY Tenant	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Benjamin Hardesty		14. MOTHER'S MAIDEN NAME Elizabeth Chaney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes W.W.I		16. SOCIAL SECURITY NO. 219-36-7712	
17. INFORMANT Mrs. Mary Hardesty-#2.		Address Same as Item #2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH minutes over 2 mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i> EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 3-26-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/30/67	
23c. NAME OF CEMETERY OR CREMATORY Alexandria Nat'l Cem.		23d. LOCATION (City or Town) (County) (State) Alexandria, Va.	
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.		25a. REC'D BY REGISTRAR DATE APR 12 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

其 碑

REF ID: A66890

1945-1946 1947-1948

$\Gamma_{\text{d}} \approx 0.8$

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04065

Item 9 Film 386 3/17/67 JK

CERTIFICATE OF DEATH

04064

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>DE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenleaf</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 473	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greenbelt Convalescent Center</u>		d. STREET ADDRESS <u>103. 6th st NE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>R. T.</u> Last <u>Hardesty</u>		4. DATE OF DEATH Month <u>3</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>f.</u>	6. COLOR OR RACE <u>w.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/25 1876</u>
9. AGE (In years last birthday) <u>90 41</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George A. Tebeault</u>		14. MOTHER'S MAIDEN NAME <u>Sarah E. White</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Gwendolyn Chilton Boston Mass</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Congestion</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Heart Disease</u> DUE TO <u> </u> (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteritis - atherosclerosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 1960</u> , 19 <u> </u> , to <u>3/12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/10</u> 19 <u>67</u> , and that death occurred at <u>1:15 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Chas. V. Pate</u>		22b. DATE SIGNED <u>3/12/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>CHAS. V. PATE</u>		22d. ADDRESS <u>335 W ST N.E. WASH D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3.15.67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Hebron Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Winchester. Virginia</u>
24. FUNERAL DIRECTOR <u>Lee Funeral Home. 300 4th st N E</u>		ADDRESS <u>Wash. D.C.</u>	
25a. REC'D BY REGISTRAR <u>MAR 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	

00000

00000

00000

[Faint, mostly illegible text and markings across the page, possibly bleed-through from the reverse side. Some faint words like "RECEIVED" and "OFFICE" are visible.]

RECEIVED
OFFICE
00000

04066

04065

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6705 - 22nd Place		d. STREET ADDRESS 6705 - 22nd Place	
3. NAME OF DECEASED (Type or print) LORETTA J HARRINGTON		4. DATE OF DEATH Month Mar. Day 2, Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 3, 1961
9. AGE (In years last birthday) 5 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Richard J. Harrington	
14. MOTHER'S MAIDEN NAME Katharina Englert		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Father Address Same as Item 2. Richard J. Harrington	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 7531 DUE TO (b) CONGENITAL BRAIN DAMAGE DUE TO (c) 10-3-61		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED CONVULSION		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10-3-1961 , to 3-2-1967 , that (I) (we) last saw the deceased alive on FEB 17 1967 , and that death occurred at 1:30 A.M. from causes and on the date stated above			
22a. SIGNATURE Donald J. [Signature]	22b. DATE SIGNED 3/2/67		22c. PHYSICIAN'S NAME (Type) HAROLD F. [Signature]
22d. ADDRESS 1552 Anderson Road S.W.		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-6-67	23c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cem.	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR MAR 10 1967	25b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

04000

INSTITUTE OF DATA

04000

Blank lined paper with faint horizontal lines and two punch holes on the right side.

THE MEDICAL EXAMINER FOR PRINCE GEORGE'S COUNTY WAS NOTIFIED AND RELEASED THE REMAINS TO US. HOSP ANDREWS TO HOSPITAL OR ATTENDING PHYSICIAN AND PREPARATION OF DEATH CERTIFICATE. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04067

CERTIFICATE OF DEATH

04066

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB		c. LENGTH OF STAY IN 1b DOA *		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUITLAND 16.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS			d. STREET ADDRESS 3001 PEARL DR, APT 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last DALE CLAYTON HARRIS			4. DATE OF DEATH Month Day Year MARCH 20 19 67		
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 11 DEC 66		9. AGE (In years last birthday) yrs. 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (County & State, or foreign country) PRINCE GEORGE'S, MD.	
13. FATHER'S NAME GARY LEROY HARRIS			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO NA		16. SOCIAL SECURITY NO. NONE		17. INFORMANT FATHER	
				Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PNEUMONITIS, BILATERAL, VIRAL ETIOLOGY, 492X DUE TO (SDII) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 11 Dec 19 66, to 20 March 19 67 that (I) (we) last saw the deceased alive on 25 Jan 19 67, and that death occurred at 1:40 PM, from causes and on the date stated above.					
22a. SIGNATURE Sidney Goldman		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 20 MARCH 67	
22c. PHYSICIAN'S NAME (Type) SIDNEY GOLDMAN, CAPT USAF MC		22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB WASH DC 20331			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/25/67	23c. NAME OF CEMETERY OR CREMATORY FT. LOGAN NAT. CEMETERY		23d. LOCATION (City or Town)	(County) (State) DENVER, COLORADO
24. FUNERAL DIRECTOR ROBERT E. WILHELM 4308 SUITLAND ROAD, SUITLAND, MARYLAND			25a. REC'D BY REGISTRAR DATE 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

7-205496

01005

01005

CERTIFICATE OF DEATH

NAME: [REDACTED] SEX: [REDACTED] AGE: [REDACTED] DATE OF BIRTH: [REDACTED]

DATE OF DEATH: [REDACTED] PLACE OF DEATH: [REDACTED]

CAUSE OF DEATH: [REDACTED]

DATE OF BURIAL: [REDACTED] PLACE OF BURIAL: [REDACTED]

NAME OF BURIAL PLACE: [REDACTED]

NAME OF BURIAL PLACE: [REDACTED]

NAME OF BURIAL PLACE: [REDACTED]

NAME OF BURIAL PLACE: [REDACTED]

NAME OF BURIAL PLACE: [REDACTED]

NAME OF BURIAL PLACE: [REDACTED]

NAME OF BURIAL PLACE: [REDACTED]

NAME OF BURIAL PLACE: [REDACTED]

NAME OF BURIAL PLACE: [REDACTED]

NAME OF BURIAL PLACE: [REDACTED]

NAME OF BURIAL PLACE: [REDACTED]

NAME OF BURIAL PLACE: [REDACTED]

NAME OF BURIAL PLACE: [REDACTED]

NAME OF BURIAL PLACE: [REDACTED]

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04068

04067

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN TB DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital					d. STREET ADDRESS 5220 56th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Ralph Middle Sheckles Last Harvey				4. DATE OF DEATH Month March Day 10 Year 1967			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-15-03		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired owner		10b. KIND OF BUSINESS OR INDUSTRY Poultry farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Franklin Pierce Harvey				14. MOTHER'S MAIDEN NAME Lulie King			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214 03 8226		17. INFORMANT Pauline F. Harvey		Address Riverdale, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4200 IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH minutes over 3 yr
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address Riverdale, Md.		22. DATE SIGNED 3-11-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 14, 1967		23c. NAME OF CEMETERY OR CREMATORY Whitfield Cemetery		23d. LOCATION (City or Town) (County) (State) Lanham Pro Georges Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		REGISTERED BY REGISTRAR DATE MAR 14 1967 REGISTRAR'S SIGNATURE Charles Judge	

[illegible]

• • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (page 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 7 will - 2386 3/17/67 kk

04069

CERTIFICATE OF DEATH

04068

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 24 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
3. NAME OF DECEASED (Type or print) Clerc W. Hawk		d. STREET ADDRESS 3701 Nicholson St.	
4. DATE OF DEATH Month March Day 11 Year 1967		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/9/04
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired examiner		10b. KIND OF BUSINESS OR INDUSTRY S Government	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Amos Hawk		14. MOTHER'S MAIDEN NAME Addie M Mc Calley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 577 42 1623	
17. INFORMANT Edith Helen Hawk		Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Cerebral Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Atherosclerosis (c) Cerebral Atherosclerosis			INTERVAL BETWEEN ONSET AND DEATH 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 1967 , to March 11, 1967 , that (I) (we) last saw the deceased alive on 3-11 1967 , and that death occurred at 2:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Donald C. Edgren		22b. DATE SIGNED PM	
22c. PHYSICIAN'S NAME (Type) DONALD C. EDGREN		22d. ADDRESS Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 14, 1967	23c. NAME OF CEMETERY OR REMOVAL George Washington	23d. LOCATION (City or Town) (County) (State) Hyattsville Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons		25. REC'D BY REGISTRAR MAR 15 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

00000

00000

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

Prince George

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04070 Item #2 a,b,c,d Film #0587 3/22/67 pg 04069

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wash.</u>	
c. LENGTH OF STAY IN lb <u>2 Mos</u>		d. STREET ADDRESS <u>4025 Argyle Terrace</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hyattsville Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Theodore George Heilbronn</u>	4. DATE OF DEATH <u>March 3 1967</u>	5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 12, 1873</u>	9. AGE (in years last birthday) <u>93 yrs.</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(Retired) - Strawfitter</u>	
10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Gardensville, New York</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Herman Heilbronn</u>	14. MOTHER'S MAIDEN NAME <u>Christina</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.	17. INFORMANT	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, cecum</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1530</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic cardiovascular disease.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>undeterm.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. — 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 22, 1966</u> , to <u>present</u> , 19 <u>67</u> , that (I) was last saw the deceased alive on <u>19</u> , and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>William F. Simpson, MD</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>William F. Simpson, MD</u>		22d. ADDRESS <u>6216 N.H. Ave. NE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>3-7-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Wash. D.C.</u>
24. FUNERAL DIRECTOR <u>Hanlon Funeral Home</u>		25a. REC'D BY REGISTRAR <u>MAR 15 1967</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>

01070

COTTON BIRD

MAR 12 1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04071

CERTIFICATE OF DEATH

04070

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AF BASE c. LENGTH OF STAY IN 1b 3 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORRESTVILLE d. STREET ADDRESS 7483 KEYSTONE LANE, APT 203 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KRIS (NMI) HEILBRUN First Middle Last		4. DATE OF DEATH MARCH 22 Month Day Year	
5. SEX FEMALE	6. CILDR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 MARCH 1967
9. AGE (In years lost birthday) yrs. 3		10. IF UNDER 1 YEAR Months Days Hours Min. 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA	
11. BIRTHPLACE (County & State, or foreign country) PRINCE GEORGE'S, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EDWARD HEILBRUN		14. MOTHER'S MAIDEN NAME JOAN CECILIA ALADICS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT FATHER		Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 6000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) PROBABLE ELECTROLYTE IMBALANCE DUE TO (c) SEPSIS AND RENAL FAILURE		INTERVAL BETWEEN ONSET AND DEATH 30 HRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 19 March , 19 67 , to 22 March , 19 67 that (X) (we) last saw the deceased alive on 22 March , 19 67 , and that death occurred at 1:00 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Herrick Jay Cohen</i>		22b. DATE SIGNED 22 March 67	
22c. PHYSICIAN'S NAME (Type) HERRICK JAY COHEN CAPT USAF MC		22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASH DC 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-24-67	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM.		23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR BERNARD DANZANSKY AND SONS		25. REC'D BY REGISTRAR WASH DC MAR 27 1967	
ADDRESS WASHINGTON DC		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

7-222647

05010

0407

2 MAY 2005

53-2-2

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04072

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04071

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b DOA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 3713 Taylor Street	
3. NAME OF DECEASED (Type or print) First Middle Last Albert Raymond Hennies		4. DATE OF DEATH Month Day Year 3 30 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 April 1901
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 30 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yardmaster		10b. KIND OF BUSINESS OR INDUSTRY R. R.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Carl Frederick Hennies		14. MOTHER'S MAIDEN NAME Lela Ann Holland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT William F. Hennies		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes - over 10 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D. M.D.		22. DATE SIGNED 3-31-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/3/67	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	23d. LOCATION (City or Town) (County) (State) Bladensburg Md
24. FUNERAL DIRECTOR Lee Funeral Home ADDRESS Washington, D.C.		25a. REC'D BY REGISTRAR APR 3 1967 DATE	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

15950

1

10

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04073

CERTIFICATE OF DEATH

04072

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	
c. LENGTH OF STAY IN 1b DOA		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 5901 Lockwood Road	
3. NAME OF DECEASED (Type or print) First Middle Last Helen F. Hines		4. DATE OF DEATH Month Day Year March 13 19 67	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/20/1899
9. AGE (In years lost birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Wash., D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Widmire		14. MOTHER'S MAIDEN NAME Elizabeth Wall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 053-18-2009	
17. INFORMANT Mr. Charles W. Hines (above address)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction (Son) DUE TO Arteriosclerosis heart disease DUE TO Generalized arteriosclerosis DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
19. INTERVAL BETWEEN ONSET AND DEATH hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1965 , 19 March 13 , 19 67 , that (I) (we) last saw the deceased alive on March 13 , 19 67 , and that death occurred at 4:37 P.M. , from causes on and on the date stated above.			
22a. SIGNATURE William C. Weintraub		22b. DATE SIGNED March 16, 1967	
22c. PHYSICIAN'S NAME (Type) William C. Weintraub, M.D.		22d. ADDRESS Professional Bldg. Greenbelt, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/16/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Wash., D.C.
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25. REC'D BY REGISTRAR DATE MAR 17 1967	
26. REGISTRAR'S SIGNATURE Charles Judge		27. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00075

00075

Prince George's

Prince George's

Prince George's

University

TOP

University

Level Jackson Road

Prince George's General Hospital

March 18

March 18

March 18

1750/1820

Female

1750/1820

Female

Physician's Information
Admission to Hospital
General Information

March 18, 1957

1750/1820

March 18, 1957

March 18, 1957

Professional Staff, General Hospital

William C. McLeod, M.D.

1750/1820

1750/1820

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04074

CERTIFICATE OF DEATH

04073

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 12 1/2 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 4219 30th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edgar Middle K. R Last Hodges				4. DATE OF DEATH Month March Day 26 Year 67			
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-25-94		9. AGE (In years birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bell Hop - Lee House - Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Wash., D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George H. Hodges				14. MOTHER'S MAIDEN NAME Mary Otts			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-03-9939		17. INFORMANT Address Mrs. Annie Hodges (above address)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Cardio-circulatory collapse DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. ② Severe malnutrition, chronic DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 3-26 , 19 67 , to 3-26 , 19 67 , that (I) (we) last saw the deceased alive on 3-26 , 19 67 and that death occurred at 10:10 PM , from causes and on the date stated above.							
22a. SIGNATURE R. U. FRANCHI		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/28/67			
22c. PHYSICIAN'S NAME (Type) R. U. FRANCHI, M.D.		22d. ADDRESS 7729 Finn's Lane Lanham Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/29/67	23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City or Town) (County) (State) Wash., D.C.			
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		ADDRESS Mt. Rainier Maryland		25a. REC'D BY REGISTRAR MAR 30 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04075					04074						
1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>						
c. LENGTH OF STAY IN 1b					d. STREET ADDRESS <u>4812 Edmondston Ave</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eugene Leland Memorial</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Lee</u> Last <u>Howard</u>			4. DATE OF DEATH Month <u>3</u> Day <u>5</u> Year <u>1967</u>								
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-16-87</u>		9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>George Howard</u>					14. MOTHER'S MAIDEN NAME <u>Symphronia Simpson</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>577-61-0127A</u>		17. INFORMANT <u>Wife, ELEANOR HOWARD</u>			Address <u>Same AS #2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GEN. ARTERIOSCLEROSIS</u> (c) <u>UNKNOWN</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>10-27</u> , 19 <u>64</u> , to <u>3-5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-28</u> 19 <u>67</u> , and that death occurred at <u>5 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>C.J. Houmann</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-5-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>C.J. HOUMANN</u>						22d. ADDRESS <u>RIVERDALE MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAR. 8, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>			23d. LOCATION (City, town or county) (State) <u>BLADENBURG, MD.</u>				
24. FUNERAL DIRECTOR <u>W.W. Chambers Co</u>				ADDRESS <u>RIVERDALE, MD.</u>		25a. REC'D BY REGISTRAR <u>MAR 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

04004

04004

MAR 8 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

04076

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04075

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>MARLOW HEIGHTS</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>MARLOW HEIGHTS</u>	
c. LENGTH OF STAY IN 1b <u>4 1/2 years</u>		d. STREET ADDRESS <u>6204-Dallas Place</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GIOVANNINA</u> Middle <u>IASCONI</u> Last _____		4. DATE OF DEATH Month <u>MARCH</u> Day <u>31</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 10, 1889</u>
9. AGE (In years last birthday) <u>77 yrs.</u>		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		11b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (County & State, or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JOHN BATTISTA</u>		14. MOTHER'S MAIDEN NAME <u>ROSA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>579-05-0682</u>	
17. INFORMANT <u>KATHERINE IASCONI</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE Heart Failure</u> <u>4/200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC Heart Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>6 to 2 10 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes MELLITUS</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH, 1967</u> , to <u>MAR. 30, 1967</u> , that (I) (we) last saw the deceased alive on <u>MAR. 30, 1967</u> , and that death occurred at <u>2:20</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Max E. Feldman MD</u>		22b. DATE SIGNED <u>3/31/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MAX E. FELDMAN M.D.</u>		22d. ADDRESS <u>5721-Temple Hills Road P. G.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/3/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>PRINCE GEORGES, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>ROBERT E. WILHELM FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>APR 3 1967</u>	
4308 SUITLAND ROAD, SUITLAND, MARYLAND		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

00078

00078

THE

PRIN

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04077

CERTIFICATE OF DEATH

04076

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chester	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greenbelt Convalescent Center 7010 Greenbelt Rd.		d. STREET ADDRESS 24th & Crosby Sts.	
3. NAME OF DECEASED (Type or print) First Jesse Middle W. Last Jester		4. DATE OF DEATH March 9, 1967 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/28/90
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant & officer Manager-		10b. KIND OF BUSINESS OR INDUSTRY Chester, Pa.	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred William Jester		14. MOTHER'S MAIDEN NAME Sarah E. Knott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 195-05-4206	
17. INFORMANT Walter H. Jester		Address 4015 Van Buren St. University Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Pneumonia DUE TO Partial Respiratory Paralysis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe Arteriosclerotic Cerebrovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 75 to 8 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from January, 1967 to March, 1967 , that (I) (we) lost saw the deceased alive on March, 1967 , and that death occurred at 10:15 P.M. from causes and on the date stated above.			
22a. SIGNATURE William A. Wimsatt		22b. DATE SIGNED 10 March 1967	
22c. PHYSICIAN'S NAME (Type) William A. Wimsatt, MD		22d. ADDRESS 3415 Hamilton St, Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE THEREOF 3/10/67	23c. NAME OF CEMETERY OR CREMATORY Chester Rural Cem.	23d. LOCATION (City or Town) (County) (State) Chester, Pa.
24. FUNERAL DIRECTOR The S.H. Hines Co.		25a. REC'D BY REGISTRAR MAR 13 1967	
25b. REGISTRAR'S SIGNATURE [Signature]		25c. REGISTRAR'S NAME [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04056

57030

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04078

CERTIFICATE OF DEATH

04077

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN Tb 65 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 222 78th Street	
3. NAME OF DECEASED (Type or print) First Kathryn Middle L Last Jewell		4. DATE OF DEATH Month March Day 12 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 Dec., 1923
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY International Asso. West Virginia	9. AGE (In years lost birthday) 43 yrs.
13. FATHER'S NAME Ira Bliss Stone		14. MOTHER'S MAIDEN NAME Nellie T. Hagan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No None		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT William H. Jewell Jr.		Address Same As #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal CA DUE TO Multiple Pulmonary emboli Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan. 4, 1967 , to March 12, 1967 , that (I) (we) last saw the deceased alive on March 12 1967 , and that death occurred on March 12, 1967 from causes and on the date stated above.			
22a. SIGNATURE Saul Schwartzbach		22b. DATE SIGNED March 13, 1967	
22c. PHYSICIAN'S NAME (Type) Saul Schwartzbach, M. D.		22d. ADDRESS 1726 Eye St. Washington, D.C. 20006	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/17/1967	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	23d. LOCATION (City or Town) (County) (State) Bladensburg Maryland
24. FUNERAL DIRECTOR W.W. CHAMBERS CO. 517 11th St. S.E. WASHINGTON D.C.		25a. REC'D BY REGISTRAR MAR 20 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5040

85020

... in the ...

total .5 diff

monte sail erl

1997-1998

150000 100000

7/1/77

10

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04079

CERTIFICATE OF DEATH

04078

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 7 hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 3810 32nd St.	
3. NAME OF DECEASED (Type or print) First Emily Middle P Last Johnson		4. DATE OF DEATH Month March Day 23 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 April 1900
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Western Union Tele. Co. - Retired		10b. KIND OF BUSINESS OR INDUSTRY Wash., D.C.	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles J. Peckham		14. MOTHER'S MAIDEN NAME Mabel A. Haskins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-22-2525	
17. INFORMANT Mr. Paul D. Johnson (above address)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO (b) Myocardial infarction DUE TO (c) Acute coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH 18 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) physician attended the deceased from July 15, 19 64 , to March 23, 19 67 , that (I) last saw the deceased alive on March 23, 19 67 , and that death occurred at 5.30 AM , from causes and on the date stated above.			
22a. SIGNATURE Don B. Cameron M.D.		22b. DATE SIGNED 3-24-67	
22c. PHYSICIAN'S NAME (Type) Don B. Cameron, M.D.		22d. ADDRESS 3503 Perry St. Mt. Rainier, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/27/67	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. REC'D BY REGISTRAR DATE MAR 28 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed, within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04078

NEW YORK

1943

Princeton University
Princeton, New Jersey
March 21, 1943
Dear Mr. Einstein:
I have your letter of March 18, 1943, and am glad to hear from you.
I am sorry that I cannot give you a more definite answer at this time.
I am sure that you will understand my position.
I am very truly yours,
Albert Einstein
Princeton, New Jersey

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04080

04079

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS Box 143	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Ernest Last Johnson		4. DATE OF DEATH Month 3 Day 28 Year 19 67	
5. SEX male	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 Dec. 1892
9. AGE (In years lost birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Sarah Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Not Stated		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mr. Roosevelt Johnson (Same as Above)		Address SON	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Hypertensive arteriosclerotic heart disease (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH minutes over 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 3-28-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) 413		23b. DATE THEREOF 4/13	
23c. NAME OF CEMETERY OR CREMATORY Church		23d. LOCATION (City or Town) (County) (State) Glennview Md	
24. FUNERAL DIRECTOR John T. Rhines & Company		25a. REC'D BY REGISTRAR APR 7 1967	
3015 12th Street N. E. Wash, D.C.		25b. REGISTRAR'S SIGNATURE Charles Judge	

STOCK

JOHN V. KILGUS, Secretary
2012 12th Street N.E., Wash. D.C.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04081

04080

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND		c. LENGTH OF STAY IN 1b 60.3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) D.O.A. ANDREW'S AIR FORCE BASE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS HQ MARINE CORPS FLIGHT SECTION	
3. NAME OF DECEASED (Type or print) WILLIAM REED JOHNSTONE		4. DATE OF DEATH MAR 18 1967		5. SEX MALE	
6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH JAN 16 1946	
9. AGE (In years last birthday) 21 yrs.		10. AGE (In years last birthday) 21 yrs.		11. BIRTHPLACE (State or foreign country) ST. CLOUD MINNESOTA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LANCE CORPORA		10b. KIND OF BUSINESS OR INDUSTRY U.S.M.C		12. CITIZEN OF WHAT COUNTRY? U.S	
13. FATHER'S NAME EARL F. JOHNSTONE		14. MOTHER'S MAIEN NAME IDA MAY UNKNOWN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES	
16. SOCIAL SECURITY NO. 477548770		17. INFORMANT ANDREW'S AIR FORCE BASE RECORDS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRAIN DAMAGE 8254 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Secondary to Skull Fracture DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH AUTO ACCIDENT		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) While at work		20c. TIME OF INJURY Month, Day, Year 3-18-1967	
20d. INJURY OCCURRED While at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ST. PAUL MINNESOTA		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 3-29-67		23. SIGNATURE DAYTON O WATKINS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/21/67		23c. NAME OF CEMETERY OR CREMATORY Fort Snelling Nat'l	
23d. LOCATION (City, town or county) (State) ST. PAUL MINNESOTA		24. FUNERAL DIRECTOR W.W. Chambers Co. Inc.		25a. REC'D BY REGISTRAR MAR 23 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		25c. ADDRESS 1400 Chapin St. N.E.		25d. DATE MAR 23 1967	

04080

04080

DEPT. OF AGRICULTURE
WASHINGTON, D. C.
MAR 3 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04082

CERTIFICATE OF DEATH

04081

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)			c. LENGTH OF STAY IN lb 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital				d. STREET ADDRESS 1765 You St., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nelson Middle _____ Last Jones				4. DATE OF DEATH Month March Day 24 Year 19 67			
5. SEX M		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 3/15/02	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		11. BIRTHPLACE (County & State, or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed				10b. KIND OF BUSINESS OR INDUSTRY unknown			
13. FATHER'S NAME Albert Jones				14. MOTHER'S MAIDEN NAME Nora ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT decedent Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, massive, left lung DUE TO (b) _____ DUE TO (c) Carcinoma with massive lymph node metastases, primary site undetermined (possibly urinary bladder) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Peptic ulcer; chronic alcoholism with chronic brain syndrome							INTERVAL BETWEEN ONSET AND DEATH 2 days unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 2/15/1967 to 3/24/67 , that (we) last saw the deceased alive on 3/24/ 1967 , and that death occurred at 12:55AM from causes and on the date stated above.							
22a. SIGNATURE <i>Moe Weiss</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/24/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.				22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/29/1967		23c. NAME OF CEMETERY OR CREMATORY Harmony		23d. LOCATION (City or Town) (County) (State) Landover, Maryland	
24. FUNERAL DIRECTOR W. E. Jarvis Co 1432 You St NW				25a. REC'D BY REGISTRAR MAR 28 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

19040

00000

Prince George

Glenn Dale (xray)

Glenn Dale Hospital

Nelson

Jones

March

1105 Fox St., N.W.

3/11/02

XX

Mario

M

VS.

unknown

unemployed

Albert Jones

Knox

Jacobson

unknown

unknown

3/20/02

11:30 AM

3/20/02

3/20/02, M.D.

Glenn Dale Hospital, Glenhurst, Md.

Lawrence, Maryland

3/20/02

initial

MAR 2 1902

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

74

MEDICAL CERTIFICATION

23a.

VR A15 (4)
20 M 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04083

CERTIFICATE OF DEATH

04082

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b One day	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 6200 Princess Garden Parkway	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Octavia M. Kagle		4. DATE OF DEATH Month Day Year March 6 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/28/89
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A.	
13. FATHER'S NAME Joseph Hacher		14. MOTHER'S MAIDEN NAME Ella Sneade	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. ----	
17. INFORMANT Miriam K Vermillion		Address Lanham, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombus Pt. coronary artery (Recent) 4201 DUE TO (b) Severe generalized atherosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 19 64 , to March 6, 1967 , that (I) (we) last saw the deceased alive on March 6 19 67 , and that death occurred at 12:30M , from causes and on the date stated above.			
22a. SIGNATURE Albert Roth		22b. DATE SIGNED P.M. 3-6-67	
22c. PHYSICIAN'S NAME (Type) Dr. Albert Roth		22d. ADDRESS 5409 Riverdale Rd., Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 9, 1967	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR MAR 13 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

00882

00882

THE FIRST-CLASS OF DEATH

200 VICTIMS

British General Hospital

March 5

October 11

1918/19

British 1918

and 1918

1918/19

British 1918/19

1918

March 5

October 11

British 1918

British 1918/19

March 5

October 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04084

CERTIFICATE OF DEATH

04083

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pro Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md. College Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4922 La Salle Road Carroll Manor Home		d. STREET ADDRESS 4323 Rowalt Dr. 4922 La Salle Road	
3. NAME OF DECEASED (Type or print) First Helen Middle R. Last Kellerman		4. DATE OF DEATH Month March Day 10 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 10, 1898
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Thomas Wallace		14. MOTHER'S MAIDEN NAME Mary Ellen Reilly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. --	
17. INFORMANT Mary Jane Kellerman		Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary Thrombosis with Myocardial Infarction DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis 9 years			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) XXXXXX attended the deceased from Feb. 5 , 19 67 , March 9 , 19 67 , that (I) we last saw the deceased alive on 3/9/ 1967 , and that death occurred at 10:23 AM from causes and on the date stated above.			
22a. SIGNATURE Thomas F Collins		22b. DATE SIGNED March 10, 1967	
22c. PHYSICIAN'S NAME (Type) Thomas F Collins, M.D.		22d. ADDRESS 322 H St. N.E. Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 14, 1967	23c. NAME OF CEMETERY OR REPOSITORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Va.
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR MAR 13 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

04083

EXHIBIT OF DEATH

04083

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04085

04084

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie		
c. LENGTH OF STAY IN b. DOA			d. STREET ADDRESS 2725 Keystone Lane		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Lucille Veronica Kelly			4. DATE OF DEATH Month Day Year 3 6 19 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-13-1903		9. AGE (In years lost birthday) yrs. 63
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) New York City		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas Malloy			14. MOTHER'S MAIDEN NAME XXXXX ?Bridget Golden		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?????	17. INFORMANT Address Walter B. Cooke Funeral Home Bronx, N.Y.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 5271 DUE TO Pulmonary emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 1 yr. over 3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 3-7-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/19/67	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	23d. LOCATION (City or Town) (County) (State) Mt. Pleasant, N.Y.		
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Inc. Baltimore, Md. 21202			25a. REC'D BY REGISTRAR MAR 13 1967	25b. REGISTRAR'S SIGNATURE J Charles Judge	

04083

04083

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04086

04085

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.		c. LENGTH OF STAY IN 1b 16.11	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nina Middle B. Last Kidwell		4. DATE OF DEATH Month March Day 17 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 20, 1893
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		12. KIND OF BUSINESS OR INDUSTRY Department store	
13. BIRTHPLACE (State or foreign country) Virginia		14. CITIZEN OF WHAT COUNTRY? U S A.	
15. FATHER'S NAME ?		16. MOTHER'S MAIDEN NAME ?	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		18. SOCIAL SECURITY NO. 214 10 7655	
19. INFORMANT Richard Ashby Kidwell		Address Brentwood, Md.	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Coronary DUE TO Heart disease & Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dayton O Watkins M.D.		22. DATE SIGNED 3-20-67	
EXAMINER'S NAME (Type) Dayton O Watkins		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Mar 21, 1967	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	
25. RECEIVED BY REGISTRAR Mar 23 1967		26. REGISTRAR'S SIGNATURE John Charles Judge	

1952

1952

1952

1952

1952

1952

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AT5ME (5)
6M 1/66

04087

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04086

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Comp Springs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Killebrew Heights</u> 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Andrews Army Air Base</u>		d. STREET ADDRESS <u>5011 Bellbrook Ct</u>	
3. NAME OF DECEASED (Type or print) <u>JOSEPH D LA GRAVE</u>		4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 25 1922</u> 4-1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Gov</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Navy Finance</u>	11. BIRTHPLACE (State or foreign country) <u>North Dakota</u>
13. FATHER'S NAME <u>Grover Legrove</u>		14. MOTHER'S MAIDEN NAME <u>Mary H Buckley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WW2</u>		16. SOCIAL SECURITY NO. <u>601-186182</u>	
17. INFORMANT <u>Mrs Dallas Redshaw</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> Acute infiltration of the liver due to DUE TO (b) <u>Hypertensive card / Cardio Vascular Disease</u> DUE TO (c) <u>Alcohol / Annot</u> Acute alcoholic intoxication			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dayton Watkins</u> M.D.		22. DATE SIGNED <u>3-18-67</u>	
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 20-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>- Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>Simmons Bros. 1661- Gd. Hope Rd. SE. Wash., DC</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 21 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

04087

04088

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04088

04087

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3343 Buchanan Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ray Middle (DARIN) Last Dearing		4. DATE OF DEATH Month 3 Day 8 Year 1967	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8-1-1916
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months 3 Days 8 Hours 16 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUS DRIVER		10b. KIND OF BUSINESS OR INDUSTRY GREY LINES	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes U.S. 11		16. SOCIAL SECURITY NO. 250 058431	
17. INFORMANT SHELDAG, RICE, RT1 Box 2D, HAVELOCK N.C.		18. INTERVAL BETWEEN ONSET AND DEATH	
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of chest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 976X DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Shot self in chest			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) Shot self in chest	
20c. TIME OF INJURY Month, Day, Year Hour a.m. unknown m. 3-3- 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) same as #2	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 3-8-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 14 March 1967	23c. NAME OF CEMETERY OR CREMATORY ALEXANDRIA NATL. CEM	23d. LOCATION (City or Town) (County) (State) ALEXANDRIA, VIRGINIA
24. FUNERAL DIRECTOR W. W. Chambers Co. Riverdale, Md.		25. REC'D BY REGISTRAR 13 1967	
25a. REGISTRAR'S SIGNATURE J. Charles Judge		25b. REGISTRAR'S SIGNATURE	

1902

1902

George George

George George

George George

George George

George George

George George

George George

George George

George George

George George

George George

George George

George George

George George

George George

George George

George George

George George

George George

George George

George George

George George

George George

George George

George George

George George

George George

George George

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #11 infor. taken from birth cert.

04089

CERTIFICATE OF DEATH

04088

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 8 hrs. 59mins	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 4263 - 58th Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Baby Girl Lang		4. DATE OF DEATH Month Day Year March 3, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1967
9. AGE (In years lost birthday) yrs. 8		IF UNDER 1 YEAR Months Days Hours Min. 8 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Pr. Geo. Col., Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Lang, Sr.		14. MOTHER'S MAIDEN NAME Grace Frances Campbell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Charles Lang, Sr.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5271 Congenital Lobar Emphysema DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 2, 1967 , to March 3, 1967 , that (I) (we) last saw the deceased alive on March 3, 1967 , and that death occurred at 5:30 PM from causes and on the date stated above.			
22a. SIGNATURE Till Bergemann, M.D.		22b. DATE SIGNED AM	
22c. PHYSICIAN'S NAME (Type) T. Bergemann		22d. ADDRESS Prof Bldg, Greenbelt, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 3/11/67	
23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp.		23d. LOCATION (City or Town) (County) (State) Cheverly PG Maryland	
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin., Cheverly, Maryland		25a. REC'D BY REGISTRAR 15 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

7-528766

04088

OFFICE OF THE

1952

George Washington

Washington

George Washington

Washington

Washington

Washington

1952 - 1953

George Washington

George Washington

George Washington

1952 - 1953

George Washington

George Washington

George Washington

George Washington

George Washington

George Washington

George Washington

George Washington

1952 - 1953

George Washington

George Washington

George Washington

George Washington

George Washington

George Washington

George Washington

George Washington

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04090 CERTIFICATE OF DEATH 04089

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek d. STREET ADDRESS Rt 1 Box 459 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elizabeth Alberta Langley First Middle Last 4. DATE OF DEATH March 26 1967 Month Day Year				5. SEX Female 6. COLOR OR RACE Cau. 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Sept. 4, 1899 9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Domestic 11. BIRTHPLACE (County & State, or foreign country) Illinois 12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Lemuel A. Dennison 14. MOTHER'S MAIDEN NAME Ella C. Jones			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. None 17. INFORMANT George M. Langley Sr., Accokeek, Md. Address Rt 1 Box 459				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral accident (b) DUE TO Hypertension (c) INTERVAL BETWEEN ONSET AND DEATH 3 days 14 years +			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from March 24, 1967, to March 26, 1967, that (I) (we) last saw the deceased alive on March 24, 1967, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE James C. Cawood 22c. PHYSICIAN'S NAME (Type) JAMES CAWOOD M.D. 22b. DATE SIGNED 3-26-67 22d. ADDRESS 2619 Branch Ave. S.E. Washington, D.C.				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 3-29-67 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery 23d. LOCATION (City, town or county) Suitland, P.G., Md. 24. FUNERAL DIRECTOR Hunt Funeral Home, Waldorf, Md. 25a. REC'D BY REGISTRAR MAR 30 1967 25b. REGISTRAR'S SIGNATURE Charles Judge			

1992

Environ Biol Fish (2015) 98:1099–1113

1998

50-105-0

24-9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04091					04090				
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf-Rural			d. STREET ADDRESS 18-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine View Gardens					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth Kathryn Lannan			4. DATE OF DEATH Month Day Year March 11, 1967						
5. SEX Female	6. COLOR OR RACE Cau.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-10-1913	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper			10b. KIND OF BUSINESS OR INDUSTRY Church Rectory		11. BIRTHPLACE (County & State, or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Cornelius Lannan			14. MOTHER'S MAIDEN NAME Anna Mc Crory						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 493-22-8605		17. INFORMANT Address 3408 Madera Mrs. Walter A. Hudson, Los Angeles, Cal.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1761 DUE TO CARCINOMATOSIS (b) DUE TO ADENOCARCINOMA VAGINAL CANN. (c)					INTERVAL BETWEEN ONSET AND DEATH 3 mos 21 yrs				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from RICK VAN, 1964, to DEATH, 1967, that (I) (we) last saw the deceased alive on 5/10 1967, and that death occurred at 5 AM, from the causes and on the date stated above.									
22a. SIGNATURE Robert W. Merkle					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 3-11-67	
22c. PHYSICIAN'S NAME (Type) ROBERT W. MERKLE M.D.					22d. ADDRESS St Charles Clinic, Waldorf, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 3-16-67		23c. NAME OF CEMETERY OR CREMATORY Mission Cemetery			23d. LOCATION (City, town or county) (State) Los Angeles, Calif.	
24. FUNERAL DIRECTOR Huntt Funeral Home, Waldorf, Md.					25a. REC'D BY REGISTRAR DATE MAR 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

00000

00000

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04092

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04091

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN IB DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 4615 Burlington Road	
3. NAME OF DECEASED (Type or print) Sadie		4. DATE OF DEATH 3 Month 12 Day 19 Year 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11 Nov. 1904
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 62 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Richard Brown		14. MOTHER'S MAIDEN NAME Mary Butler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Richard Jackson-son-6707		Address Eads St., N.E.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH minutes unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 3-13-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/16/67	23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park	23d. LOCATION (City or Town) (County) (State) Maryland
24. FUNERAL DIRECTOR John T. Stewart, Jr. ADDRESS Stewart Funeral Home-4001 Benning Rd.,		25a. REC'D BY REGISTRAR 16 DATE 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

04081

04081

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

x

x

1-1-1

x

George's

George's

George's

George's

George's

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04093

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04092

1. PLACE OF DEATH a. COUNTY Prince Geo.		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Choverly		c. LENGTH OF STAY IN lb D.O.A.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		d. STREET ADDRESS 4404 - 30th St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Stephen J. Liston		4. DATE OF DEATH Month March Day 19 Year 1967		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/18/1900		9. AGE (In years last birthday) yrs. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Dennis Liston		14. MOTHER'S MAIDEN NAME Eileen White		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Florence G. Liston (above address)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH inst		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		22. DATE SIGNED 3-20-67		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/22/67	
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Com.		23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.		24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. REC'D BY REGISTRAR MAR 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		26. ACTUAL SIGNATURE Dayton O. Watkins		27. EXAMINER'S NAME (Type) DAYTON O. WATKINS	

00000

00000

THE UNITED STATES OF AMERICA

OFFICE OF THE

SECRETARY OF THE

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04094

CERTIFICATE OF DEATH

04093

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 4 hours	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier			116-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 2906 Bunker Hill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ruth P. Little				4. DATE OF DEATH Month Day Year March 6 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 8/15/99		9. AGE (In years lost birthday) yrs. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (County & State, or foreign country) Hinton, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Parker				14. MOTHER'S MAIDEN NAME Lucinda McVey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. Harold R. Little (above address)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST, Pul. Embolism, Branchia INTERVAL BETWEEN ONSET AND DEATH 16 21 DUE TO EMPHYSEMA & LEFT PNEUMONECTOMY, Pul. abscess Rt upper lobe 7 months. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO BRONCHOGENIC CARCINOMA 6 months. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hepatomegaly, Nephrotic syndrome.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour :o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 8, 1966 , to MARCH 6, 1967 , that (I) (we) last saw the deceased alive on March 6, 1967 , and that death occurred at 2:10 PM , from causes and on the date stated above.							
22a. SIGNATURE Roy G. Klepser				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/6/67	
22c. PHYSICIAN'S NAME (Type) ROY G. KLEPSER MD				22d. ADDRESS 1835 EYE ST NW WASHINGTON, DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/10/67		23c. NAME OF CEMETERY OR CREMATORY Chestnut Grove Cem.		23d. LOCATION (City or Town) (County) (State) Herndon, Va.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.				ADDRESS Mt. Rainier Maryland		25. REGISTAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04093

04093

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

CARDIAC ARREST

EMERGENCY

BRONCHOSCOPY

WATERBURY, HOSPITAL

George's

George's

George's

George's

George's

ROY G. KLEINER MD. 1832 EYE ST NW WASHINGTON DC

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #11, 12, 13 & 14 Film #G387 1/3/67 pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT

04095

04094

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE District Of Columbia b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN IB 37 hrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		47-3
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d. STREET ADDRESS 1335 11th. Street, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Edward Middle Livingston Last			4. DATE OF DEATH Month 3 Day 16 Year 19 67		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-3-1916	9. AGE (In years lost birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North, S.C.	
13. FATHER'S NAME Kit Livingston			14. MOTHER'S MAIDEN NAME Henrietta Thomas		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage, left internal capsule 331X DUE TO Essential hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe		M.D.		22. DATE SIGNED 3-17-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 3-24-67	23c. NAME OF CEMETERY OR CREMATORY Alexander National	23d. LOCATION (City or Town)	(County)	(State) Alexander Virginia
24. FUNERAL DIRECTOR Universal Funeral Home		ADDRESS 816 H St. N.E.		25a. REC'D BY REGISTRAR MAR 27 1967	25b. REGISTRAR'S SIGNATURE J Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

100000

Director of Columbia

Director of Columbia

Director of Columbia

Director of Columbia

Director of Columbia

Director of Columbia

Director of Columbia

Director of Columbia

Director of Columbia

Director of Columbia

Director of Columbia

Director of Columbia

Director of Columbia

Director of Columbia

Director of Columbia

Director of Columbia

Director of Columbia

Director of Columbia

Director of Columbia

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04096

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04095

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN b DOA		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d. STREET ADDRESS 2808 McComas Ave.		
3. NAME OF DECEASED (Type or print) George Fulton Long			4. DATE OF DEATH Month 3 Day 9 Year 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-9-1915	9. AGE (In years last birthday) 51 yrs.	10. IF UNDER 1 YEAR Months 9 Days 19 Hours 67 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Bergman's Laundry		11. BIRTHPLACE (State or foreign country) Allentown, Penna.	
13. FATHER'S NAME Fulton Long			14. MOTHER'S MAIDEN NAME Rachel Sherrer		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 226-16-2543		17. INFORMANT Mrs. Hilda Long	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH minutes over 15 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work _____ of work _____	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 3-9-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		RIVERDALE, MD.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION REMOVAL (Specify) Cremation		23b. DATE THEREOF March 13, 1967		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory	
23d. FUNERAL DIRECTOR John B. Thomas		23e. ADDRESS 8434 Georgia Avenue		23f. REGISTRAR'S SIGNATURE Charles Judge	
23g. NAME OF FUNERAL HOME Warner E. Humphrey, Inc.		23h. ADDRESS Silver Spring, Md.		23i. DATE MAR 13 1967	

04005

04005

Department

Division

Section

Washington

and

Office

1000 Columbia Ave.

1000 Columbia Ave.

June

1954

1954

1954-1955

1954-1955

1954-1955

1954-1955

1954-1955

1954-1955

1954-1955

1954-1955

1954-1955

1954-1955

1954-1955

1954-1955

1954-1955

X

John F. Kennedy, Jr.

1954-1955

1954-1955

1954-1955

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04097

04096

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS 4227 30th. Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Henry		4. DATE OF DEATH Month 3 Day 3 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 March 1903
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 3 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor-Fitter		10b. KIND OF BUSINESS OR INDUSTRY Woodward & Lothrop	
11. BIRTHPLACE (State or foreign country) Frankfort, Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hienrsch Lott		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-01-3898	
17. INFORMANT Mrs. Eva Lott (above address)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Heart failure DUE TO Hypertensive arteriosclerotic heart disease (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH minutes unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 3-3-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/6/67	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25. REC'D BY REGISTRAR Maryland	
26. DATE MAR 7 1967		27. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04098

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 18 & 21, Film 8-21/67 cag

04097

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 5420 55th Place	
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Kevin Lynch		4. DATE OF DEATH Month Day Year 3 24 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-6-67
9. AGE (In years last birthday) yrs. 18		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME William P. Lynch		14. MOTHER'S MAIDEN NAME Catherine Lacey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT William P. Lynch Same as #2 (father)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Undetermined DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) SDII DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i> M.D.		22. DATE SIGNED 3-25-67	
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/27/67	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	23d. LOCATION (City or Town) (County) (State) Silver Spring Montgomery Md.
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md		25a. REC'D BY REGISTRAR MAR 28 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

77005863

70040

70040

X

X

418 54 1000

1000 54 418

04099

CERTIFICATE OF DEATH

04098

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>618 10th Street</u>		d. STREET ADDRESS <u>618 10th Street</u>	
3. NAME OF DECEASED (Type or print) <u>Grace</u> First Middle Last <u>mack</u>		4. DATE OF DEATH Month <u>3</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-17-1885</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Howard Co, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Solomon</u>		14. MOTHER'S MAIDEN NAME <u>Mary S. Wood</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Milton Mack</u> Address <u>3001 Lynn Falls Pkwy Baltimore, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO (b) <u>Same</u> DUE TO (c) <u>Arteriosclerosis (Cerebral)</u>	
19. INTERVAL BETWEEN ONSET AND DEATH <u> </u>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>6 - 1958</u> to <u>3-24, 1967</u> , that (I) (we) lost the deceased on <u>3-23, 1967</u> , and that death occurred at <u>2:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Edolo Pirandrea</u> M.D.		22b. DATE SIGNED <u>3-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u> </u>		22d. ADDRESS <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Laurel Prince Georges Md.</u>
24. FUNERAL DIRECTOR <u>Robert L. Jarreau</u> ADDRESS <u>Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u> </u> DATE <u>30 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04098

DEPARTMENT OF DEATH

04098

Cerebral Ischemia

Brain

Artificially (Cerebral)

3-23 3-24 3-25 3-26 3-27 3-28 3-29 3-30 3-31 4-1 4-2 4-3 4-4 4-5 4-6 4-7 4-8 4-9 4-10 4-11 4-12 4-13 4-14 4-15 4-16 4-17 4-18 4-19 4-20 4-21 4-22 4-23 4-24 4-25 4-26 4-27 4-28 4-29 4-30 5-1 5-2 5-3 5-4 5-5 5-6 5-7 5-8 5-9 5-10 5-11 5-12 5-13 5-14 5-15 5-16 5-17 5-18 5-19 5-20 5-21 5-22 5-23 5-24 5-25 5-26 5-27 5-28 5-29 5-30 5-31 6-1 6-2 6-3 6-4 6-5 6-6 6-7 6-8 6-9 6-10 6-11 6-12 6-13 6-14 6-15 6-16 6-17 6-18 6-19 6-20 6-21 6-22 6-23 6-24 6-25 6-26 6-27 6-28 6-29 6-30 7-1 7-2 7-3 7-4 7-5 7-6 7-7 7-8 7-9 7-10 7-11 7-12 7-13 7-14 7-15 7-16 7-17 7-18 7-19 7-20 7-21 7-22 7-23 7-24 7-25 7-26 7-27 7-28 7-29 7-30 7-31 8-1 8-2 8-3 8-4 8-5 8-6 8-7 8-8 8-9 8-10 8-11 8-12 8-13 8-14 8-15 8-16 8-17 8-18 8-19 8-20 8-21 8-22 8-23 8-24 8-25 8-26 8-27 8-28 8-29 8-30 8-31 9-1 9-2 9-3 9-4 9-5 9-6 9-7 9-8 9-9 9-10 9-11 9-12 9-13 9-14 9-15 9-16 9-17 9-18 9-19 9-20 9-21 9-22 9-23 9-24 9-25 9-26 9-27 9-28 9-29 9-30 10-1 10-2 10-3 10-4 10-5 10-6 10-7 10-8 10-9 10-10 10-11 10-12 10-13 10-14 10-15 10-16 10-17 10-18 10-19 10-20 10-21 10-22 10-23 10-24 10-25 10-26 10-27 10-28 10-29 10-30 10-31 11-1 11-2 11-3 11-4 11-5 11-6 11-7 11-8 11-9 11-10 11-11 11-12 11-13 11-14 11-15 11-16 11-17 11-18 11-19 11-20 11-21 11-22 11-23 11-24 11-25 11-26 11-27 11-28 11-29 11-30 12-1 12-2 12-3 12-4 12-5 12-6 12-7 12-8 12-9 12-10 12-11 12-12 12-13 12-14 12-15 12-16 12-17 12-18 12-19 12-20 12-21 12-22 12-23 12-24 12-25 12-26 12-27 12-28 12-29 12-30 12-31

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04100

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04099

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b DOA		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Alvin James Maggard			4. DATE OF DEATH Month Day Year 3 9 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-22-1911	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Gas Station		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME JESSIE E. MAGGARD			14. MOTHER'S MAIDEN NAME ELLIE HARPER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give year and dates of service) WWII		16. SOCIAL SECURITY NO.		17. INFORMANT Address Roy A. Green Appalachia, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					INTERVAL BETWEEN ONSET AND DEATH minutes over 1 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 3-10-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-13-67	23c. NAME OF CEMETERY OR CREMATORY GLENCOE	23d. LOCATION (City or Town) (County) (State) BIG STONE GAP, VA.	
24. FUNERAL DIRECTOR ADDRESS GASCH'S 4739 Baltimore Ave. Hyattsville, Md.			25a. REC'D BY REGISTRAR DATE MAR 13 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	

0000

0000

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 801 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #7 Film #G307 3/31/67 pc
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04101

04100

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 3426 79th. Avenue			
3. NAME OF DECEASED (Type or print) First Francis Middle Earl Last Manion				4. DATE OF DEATH Month 3 Day 22 Year 19 67			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 28 Aug. 1901	
9. AGE (In years last birthday) 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lt. Fire Dept.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Manion				14. MOTHER'S MAIDEN NAME Mary Vangueder			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Olie G. Manion Same As # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure H200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH minutes over 1 year.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D.				22. DATE SIGNED 3-22-67			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/25/67		23c. NAME OF CEMETERY OR CREMATORY Wash. National Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges, Maryland	
24. FUNERAL DIRECTOR Robert E. Wilhelm Address Federal Home 4308 Suitland Road, Suitland Maryland				25a. REC'D BY REGISTRAR APR 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

00110

00110

James George's

James George's

James George's

James George's

James George's

James George's

James George's

James George's

James George's

James George's

James George's

James George's

James George's

James George's

James George's

James George's

James George's

James George's

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04102

CERTIFICATE OF DEATH

04101

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sanham</u>				c. LENGTH OF STAY IN 1b <u>8 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u> <u>16-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Magnolia Gardens Nursing Home</u>				d. STREET ADDRESS <u>3905 Carwell Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jack</u> First <u>(NMD)</u> Middle <u>Marcus</u> Last				4. DATE OF DEATH Month <u>Mar.</u> Day <u>3</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 1, 1891</u> <u>75</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Hotel worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotels</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>057-01-6438</u>		17. INFORMANT <u>Joseph Marcus</u> Address <u>Same as #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> <u>acute Coronary Occlusion</u> DUE TO (b) <u>Arterio Sclerotic Heart Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> , to <u>Mar 3</u> , 19 <u>67</u> , that (I) (we) lost the deceased alive on <u>Mar 3</u> , 19 <u>67</u> , and that death occurred at <u>9:00</u> AM, from causes and on the date stated above.							
22a. SIGNATURE <u>Wm. Greco</u>				22b. DATE SIGNED <u>3/3/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Wm. Greco</u>	
22d. ADDRESS <u>Riverdale, Md.</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/6/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince George County, Md.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc., 8434 Ga., Ave., S.S., Md.</u>				25a. REC'D BY REGISTRAR <u>MAR 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10120

CERTIFICATE

0030

00-10-20

10120

MEDICAL CERTIFICATION

VR A15 (4)
20M S-63

04103

04103

PHILIP CHERRY

PHILIP CHERRY

WYATTVILLE

WYATTVILLE

3900 KOLLEROW DRIVE

3900 KOLLEROW DRIVE

12 1967

MARSHALLS

MARSHALLS

WHITE

POLICE

MENIGHT

EVA BECKNER

OSIAS KATA

3900 KOLLEROW DRIVE

NO

11-17-67 WYATTVILLE, WYATTVILLE

SHOULD HAVE BEEN A GOOD INVESTIGATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04104

04103

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN TB DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ronald				4. DATE OF DEATH March 14, 1967			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 24 Aug. 1956	
9. AGE (In years last birthday) 10 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Massey				14. MOTHER'S MAIDEN NAME Rosal Thomas			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Rosal Massey Address 1014-62nd Pl.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 9298 IMMEDIATE CAUSE (a) Drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned while swimming in creek.			
20c. TIME OF INJURY Month, Day, Year 6:45pm 3-14-1967				20d. INJURY OCCURRED 2 While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cheverly, Md.				20f. (City or town) (County) (State) Cabin Branch creek, near 62nd Ave.,			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
22. ACTUAL SIGNATURE John Kehoe M.D.				22. DATE SIGNED 3-15-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) 3-18-67				23b. DATE THEREOF 3-18-67			
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery Washington DC				23d. LOCATION (City or town) (County) (State) Washington DC			
24. FUNERAL DIRECTOR H.S. Washington Sons ADDRESS 4925 Penn Ave NE				25. RECEIVED BY REGISTRAR Charles Judge DATE MAR 20 1967			

04103

04103

Prison Service

Prison Service

Prison Service

Prison Service

Prison Service

Prison Service

Prison Service

Prison Service

Prison Service

Prison Service

Prison Service

Prison Service

Prison Service

Prison Service

Prison Service

Prison Service

X

X

X

X

John Jones, 1.1.1. Birmingham, 1.1.1.

FOR STATE
HEALTH DEPT.

04105

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04104

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS 4912 42nd Place	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Benjamin Middle Archibald Last McClay		4. DATE OF DEATH Month March Day 11 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-1-92
9. AGE (In years birth day) 74 yrs.		10. IF UNDER 1 YEAR Months 7 Days 11 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Auditor		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govern.	
11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew E. McClay		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 577-56-5124	
17. INFORMANT Doris V. Whitney		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) unknown			INTERVAL BETWEEN ONSET AND DEATH minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 3-11-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-14-67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Md.	
24. FUNERAL DIRECTOR Lee Funeral Home		ADDRESS Washington, D.C.	

VR A15ME (5)
6M 1/67

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00100

00100

Primo Group, Inc. (New York)
Chevrolet
Primo Group, Inc. (New York)
Primo Group, Inc. (New York)
Primo Group, Inc. (New York)

Primo Group, Inc. (New York)
Primo Group, Inc. (New York)
Primo Group, Inc. (New York)
Primo Group, Inc. (New York)
Primo Group, Inc. (New York)

Primo Group, Inc. (New York)
Primo Group, Inc. (New York)
Primo Group, Inc. (New York)
Primo Group, Inc. (New York)
Primo Group, Inc. (New York)

Primo Group, Inc. (New York)
Primo Group, Inc. (New York)
Primo Group, Inc. (New York)
Primo Group, Inc. (New York)
Primo Group, Inc. (New York)

Primo Group, Inc. (New York)
Primo Group, Inc. (New York)
Primo Group, Inc. (New York)
Primo Group, Inc. (New York)
Primo Group, Inc. (New York)

Primo Group, Inc. (New York)
Primo Group, Inc. (New York)
Primo Group, Inc. (New York)
Primo Group, Inc. (New York)
Primo Group, Inc. (New York)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04106

CERTIFICATE OF DEATH

04107

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			
c. LENGTH OF STAY IN 1b <u>wife</u>				d. STREET ADDRESS <u>5418 Macbeth St.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5418 Macbeth Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARGARET VICTORIA MCCLUNG</u>				4. DATE OF DEATH <u>March 31 1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 27 1884</u>	
9. AGE (In years last birthday) <u>82 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u> </u>			
13. FATHER'S NAME <u>Conrad Zink</u>				14. MOTHER'S MAIDEN NAME <u>Mary Weaver</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>				16. SOCIAL SECURITY NO. (If yes give war or dates of service) <u> </u>			
17. INFORMANT <u>Conrad D. McClung-son</u>				Address <u>Ellicott City Md.</u>			
18. CAUSE OF DEATH [Enter only one cause pertinent for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200 Congestive Heart Failure</u>							<u>10 days</u>
Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Heart Disease</u>							<u>5 yrs</u>
(a), stating the underlying cause last. (c) <u>Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 31 1967</u> to <u>date</u> 19 <u>67</u> , that (I) <u>(the)</u> last saw the deceased alive on <u>Mar 31 1967</u> , and that death occurred <u>April 1 1967</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Warren B. Burch</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Mar 31 1967</u>	
22c. PHYSICIAN'S NAME <u>WARREN B. BURCH</u>				22d. ADDRESS <u>405 A St S.E. Wash 3, D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-3-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Meadow Ridge Memo. Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Elkridge, Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Lee Fun. Home</u>				ADDRESS <u>300 4th St. N.E. Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>APR 5 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>			

04100

04100

SAID KNOX ST

Control D. V. ...

APR 1 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04107

CERTIFICATE OF DEATH

04105

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 8 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deale		12-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS Mason Beach Road	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Iva Middle McDaniel Last		4. DATE OF DEATH Month March Day 4, Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/8/96
9. AGE (In years) 70 (last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME William C. Jones		14. MOTHER'S MAIDEN NAME Lennette Marshall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 219-543474	
17. INFORMANT Ed. Johnson		Address A.E. McDowell DEALE, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1551 Peripheral Circulatory Collapse DUE TO (b) Carcinomatous DUE TO (c) Carcinoma of Gall Bladder		INTERVAL BETWEEN ONSET AND DEATH 6 hrs Unk Unk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1948, to March 4, 1967, that (I) (we) last saw the deceased alive on 4 Mar 1967, and that death occurred at 2:25 PM, from causes and on the date stated above.			
22a. SIGNATURE R. B. Danner		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAR 7, 1967	
23c. NAME OF CEMETERY OR CREMATORY FRIENDSHIP		23d. LOCATION (City or Town) (County) (State) FRIENDSHIP, MD	
24. FUNERAL DIRECTOR T. H. Hensley, Galesville, MD		25a. REC'D BY REGISTRAR DATE MAR 13 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

100

THE STATE OF TEXAS

100

James A. [illegible]

James A. [illegible]

James A. [illegible]

James A. [illegible]

James A. [illegible]

James A. [illegible]

James A. [illegible]

James A. [illegible]

James A. [illegible]

James A. [illegible]

James A. [illegible]

James A. [illegible]

James A. [illegible]

James A. [illegible]

James A. [illegible]

James A. [illegible]

James A. [illegible]

James A. [illegible]

James A. [illegible]

James A. [illegible]

James A. [illegible]

James A. [illegible]

James A. [illegible]

James A. [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04108

04106

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 5610 - 54th Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Cora A. McKinney				4. DATE OF DEATH Month Day Year March 1, 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/15/81	
9. AGE (In years last birthday) 86 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Wilmer Rowe			
14. MOTHER'S MAIDEN NAME Amanda Carter				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 578 03 3273				17. INFORMANT Marie M Russell Address Riverdale, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO (b) Coronary Occlusion DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from Aug. 1966 , to March 1, 1967 , that (I) (we) last saw the deceased alive on March 1, 1967 , and that death occurred at 9:50 PM from causes and on the date stated above.			
22a. SIGNATURE <i>Thomas G. Maloney</i> M.D.				22b. DATE SIGNED Mar 3, 1967		22c. PHYSICIAN'S NAME (Type) Thomas G. Maloney, M.D.	
22d. ADDRESS 4714-71st Ave. Landover Hills, Maryland				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF March 4, 1967				23c. NAME OF CEMETERY OR CREMATOR Rock Creek Cemetery		23d. LOCATION (City or Town) (County) (State) Washington D. C.	
24. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE MAR 6 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04108

RECORDS OF DEATH

04108

United States

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04109

CERTIFICATE OF DEATH

04108

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Brentwood	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. STREET ADDRESS 3700 Tilden Street	
3. NAME OF DECEASED (Type or print) George First D Middle McMichael Last		4. DATE OF DEATH Month March Day 23 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 3, 1883
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Owner		10b. KIND OF BUSINESS OR INDUSTRY Transit Co.	
11. BIRTHPLACE (County & State, or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME John V. McMichael		14. MOTHER'S MAIDEN NAME Elizabeth Cheek	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578 48 5516	
17. INFORMANT George W. McMichael		Address Same as #2 (son)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 2001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pancytopenia DUE TO (c) Lymphosarcoma		INTERVAL BETWEEN ONSET AND DEATH 4 hours 4 weeks 4 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 19 47 to March , 19 67 , that (we) saw the deceased alive on MARCH 22 19 67 , and that death occurred at 2:10 AM , from causes and on the date stated above.			
22a. SIGNATURE Benjamin S. Miller		22b. DATE SIGNED March 23 67	
22c. PHYSICIAN'S NAME (Type) Benjamin S Miller		22d. ADDRESS Mt Rainier, Md.	
23a. BURIAL CREMATION, EMBALM (Specify) Burial		23b. DATE THEREOF 3/25/67	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor, P.G. M.d	
24. FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR MAR 27 1967		25b. REGISTRAR'S SIGNATURE J Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corpan papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

80110

UNITED STATES DEPARTMENT OF THE INTERIOR

1911

Geological Survey

Washington, D.C.

Geological Survey

Washington, D.C.

Geological Survey

Washington, D.C.

Washington, D.C.

Geological Survey

Washington, D.C.

1911

Geological Survey

Geological Survey

1911

Geological Survey

Washington, D.C.

Geological Survey

Washington, D.C.

Geological Survey

Washington, D.C.

Geological Survey

Washington, D.C.

Geological Survey

1911

Geological Survey

Washington, D.C.

Geological Survey

Geological Survey

Washington, D.C.

Geological Survey

Geological Survey

Washington, D.C.

Geological Survey

Geological Survey

Washington, D.C.

Geological Survey

Geological Survey

Washington, D.C.

Geological Survey

Geological Survey

Washington, D.C.

Geological Survey

Geological Survey

Washington, D.C.

Geological Survey

Geological Survey

Washington, D.C.

Geological Survey

Geological Survey

Washington, D.C.

Geological Survey

Geological Survey

Washington, D.C.

Geological Survey

Geological Survey

Washington, D.C.

Geological Survey

Geological Survey

Washington, D.C.

Geological Survey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04110		04109	
1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORRESTVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest HEIGHTS</u>	
c. LENGTH OF STAY IN lb <u>4 days</u>		d. STREET ADDRESS <u>5004 DIXON ST.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Regent Nursing & Rehabilitative Centre</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>S.</u> Last <u>MERRICK</u>		4. DATE OF DEATH Month <u>3</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-18-1886</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH SPIESMAN</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE KNEIB</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>208-14-0455</u>	
17. INFORMANT <u>MRS ED. J. KANE</u>		Address <u>GOSHEN RD. NEWTOWN SQUARE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>acute coronary occlusion.</u> DUE TO (c) <u>arteriosclerotic heart disease.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.V.A. 2 left hemiparesis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>5:45 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Kelvin L. Minchin</u>		22b. DATE SIGNED <u>3/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>KELVIN L. MINCHIN</u>		22d. ADDRESS <u>6400 MARLBORO PIKE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-29-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST DENIS</u>		23d. LOCATION (City or town) (County) (State) <u>HAVERTOWN DELAWARE PA.</u>	
24. FUNERAL DIRECTOR <u>Robert T. Roche</u>		25a. REC'D BY REGISTRAR <u>MAR 29 1967</u>	
ADDRESS <u>5350 CEDAR AVE PHILA. PA</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

04100

04100

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "The" and "and" are visible.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04111		04110	
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bronx, New York	
c. LENGTH OF STAY IN b DOA		d. STREET ADDRESS 1934 Yates Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph NMI Mischel		4. DATE OF DEATH Month Day Year March 10 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1900
9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Ret. Painter		10b. KIND OF BUSINESS OR INDUSTRY Homes	
11. BIRTHPLACE (State or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Matthew Mischel		14. MOTHER'S MAIDEN NAME Katherine Scheurich	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 115 12 4993	
17. INFORMANT Florence L. Mischel Same as #2 (wife)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) over 13 yrs		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 3-11-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/14/67	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City or Town) (County) (State) Bronx N. Y.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		REGISTERAR'S SIGNATURE Charles Judge	

MAR 14 1967
DATE

01110

01110

1. The first of these is the fact that the

the second of these is the fact that the

the third of these is the fact that the

the fourth of these is the fact that the

the fifth of these is the fact that the

the sixth of these is the fact that the

the seventh of these is the fact that the

(also) the eighth of these is the fact that the

the ninth of these is the fact that the

the tenth of these is the fact that the

1. The first of these is the fact that the

the second of these is the fact that the

the third of these is the fact that the

the fourth of these is the fact that the

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3, Page 1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

04112

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #8 Film #G387 3/27/67 pg

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04111

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradbury Heights 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 5210 Alton Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Walter Misiewicz			4. DATE OF DEATH Month Day Year 3 11 1967		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov 1941	9. AGE (In years lost birthday) 45 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penn.	
13. FATHER'S NAME Walter Misiewicz			14. MOTHER'S MAIDEN NAME Helene Gayda		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 189-14-5493		17. INFORMANT Walter Misiewicz Int Pleasant Pa Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 8164 IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bilateral Hemothorax DUE TO (c) Multiple Rib fractures (Trauma - auto accident)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) passenger in car involved in collision			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 3-10 1967 11:50pm		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) U.S. Rte. 1 at Rte. 193	
				20f. (City or town) (County) (State) P.G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe		M.D.		22. DATE SIGNED 3-11-67	
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) 3-14-1967		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Transfiguration Cemetery	
				23d. LOCATION (City or Town) (County) (State) East Huntingdon Twp West Pa	
24. FUNERAL DIRECTOR Michael P. Gulone 204 E. 1st St. Pleasant Pa.		ADDRESS		25a. REC'D BY REGISTRAR MAR 17 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

\$1150

1120

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04113						04112					
1. PLACE OF DEATH e. COUNTY PRINCE GEORGES MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY PRINCE GEORGES					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HILLCREST HEIGHTS						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HILLCREST HEIGHTS					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5517 24th AVENUE						d. STREET ADDRESS 5517 24th AVENUE					
3. NAME OF DECEASED (Type or print) First BLANCHE Middle SCULLIN Last MORGAN						4. DATE OF DEATH Month MARCH Day 7 Year 19 67					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH APRIL 16, 1900		9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days	
										IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SCHOOL TEACHER SCHOOL						10b. KIND OF BUSINESS OR INDUSTRY SCHOOL		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN ROBERT SCULLIN						14. MOTHER'S MAIDEN NAME CLARA R. PICKENS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give year or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT CHARLES R. SCULLINS Address SAME AS # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) 1538 Metastatic Carcinoma of the liver DUE TO Adenocarcinoma of the colon Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 6 mon. 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1967 , to Mar 7, 1967 , that (I) (we) last saw the deceased alive on Mar 1, 1967 , and that death occurred at 3:45 PM , from the causes and on the date stated above.											
22a. SIGNATURE Frank J Talbot M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/7/67			
22c. PHYSICIAN'S NAME (Type) Frank J Talbot M/D						22d. ADDRESS 4273 Branch Ave Marlow Heights Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF March 11, 1967		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY			23d. LOCATION (City, town or county) (State) PARKERSBURG, WEST VIRGINIA			
24 FUNERAL DIRECTOR'S SIGNATURE WILHELM FUNERAL HOME 4308 SUITLAND RD. MARYLAND						ADDRESS SUITLAND		25a. REC'D BY REGISTRAR MAR 13 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

31110

STATE OF TEXAS

31110

STATE OF TEXAS
COUNTY OF [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

FOR STATE
HEALTH DEPT.

04114

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04113

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS Box 25A, Sands Road	
3. NAME OF DECEASED (Type or print) Helen T Myles		4. DATE OF DEATH Month 3 Day 26 Year 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 Nov. 1906
9. AGE (In years lost birthday) 60 yrs.		10. BIRTHPLACE (State or foreign country) Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. CITIZEN OF WHAT COUNTRY? Maryland	
13. FATHER'S NAME David Simms		14. MOTHER'S MAIDEN NAME Helen Diggs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT John E. Myles-son		Address -4624 Blagden Terrace	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH minutes unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 3-27-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/31/67	23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park	23d. LOCATION (City or Town) (County) (State) Maryland
24. FUNERAL DIRECTOR Stewart Funeral Home-4001 Benning Rd.,		25a. REC'D BY REGISTRAR N. MAR 29 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

61150

31140

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	March 13, 1967	Ft. Lincoln Cemetery	Bladensburg	Maryland	
24. FUNERAL DIRECTOR	ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	

VR A15 (4)
25M 1/67

04110

04110

18 Years

At Home

575-20-1110-5

None

None

March 23, 1967 Ft. Lincoln Cemetery, Maryland

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

05680

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05680

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland	
c. LENGTH OF STAY IN b DOA		d. STREET ADDRESS 7831 Penna. Ave., Apt 202	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John Christopher Orsini		4. DATE OF DEATH Month Day Year 3 23 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 April 1966
9. AGE (In years last birthday) yrs. 11		IF UNDER 1 YEAR Months Days Hours Min. 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert F. Orsini		14. MOTHER'S MAIDEN NAME Mary Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. ----	
17. INFORMANT Mrs. Mary Smith Orsini-#2		Address Same as Item	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Undetermined DUE TO SDII Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Associated with pulmonary congestion, bilateral Pulmonary atelectasis, Focal (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 3-23-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	3/27/67	Mt. Carmel Cemetery	Upper Marlboro, Md.
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.		25a. REC'D BY REGISTRAR APR 12 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE J Charles Judge	

02880

02880

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

177 on George St.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (1)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04116

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04115

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 15 DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		12-2
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d. STREET ADDRESS Rt. 1, Box 133		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle Lee Last Paddy			4. DATE OF DEATH Month 3 Day 13 Year 19 67		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 Oct. 1937	9. AGE (In years lost birthday) 29 yrs.	IF UNDER 1 YEAR Months 13 Days 19 Hours 67 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator - Heavy Equip. Construction		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Annapolis, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Russell			
14. MOTHER'S MAIDEN NAME Gladys Kirby		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 8194		17. INFORMANT Mrs. Katherine Z. Paddy, same as 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain DUE TO Fracture of skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH 5
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in car which struck bridge abutment.			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 12:51am m. 3-13- 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 450 at Whitfield Chapel Rd. Prince Geo. Co	
20f. (City or town) (County) (State) Laurel, Prince George's, Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 3-13-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 16 March 67		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		25a. REC'D BY REGISTRAR MAR 16 1967			
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge			

04115

04115

James G. ...

James G. ...

James G. ...

James G. ...

James G. ...

James G. ...

James G. ...

James G. ...

James G. ...

James G. ...

James G. ...

James G. ...

James G. ...

James G. ...

James G. ...

James G. ...

James G. ...

James G. ...

James G. ...

James G. ...

James G. ...

James G. ...

James G. ...

James G. ...

James G. ...

James G. ...

James G. ...

James G. ...

James G. ...

James G. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04117

CERTIFICATE OF DEATH

04118

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 308--Huron Dr., S. E.		d. STREET ADDRESS 308--Huron Dr., SE	
3. NAME OF DECEASED (Type or print) First Middle Last Gladys K. Page		4. DATE OF DEATH Month Day Year March 11th 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10-1900
9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob XXXXX Wooge		14. MOTHER'S MAIDEN NAME Carrie Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Colleen P. Mader		Address Same as Item #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Coronary Thrombosis DUE TO (b) Diabetes Melitus & Hypertension DUE TO (c) Obesity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3 sudden 6 years after life	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/12/1954, 19__, to 3/11/1967, 19__, that (I) (we) last saw the deceased alive on 3/11/1967 19__, and that death occurred at N/A M, from causes and on the date stated above.			
22a. SIGNATURE Dr. Etienne Szollosi		22b. DATE SIGNED 3-11-1967	
22c. PHYSICIAN'S NAME (Type) Dr. Etienne Szollosi		22d. ADDRESS # 2 Parkway Dr., SE Forest Hgts. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 14-67	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l.	23d. LOCATION (City or Town) (County) (State) Arlington, Va.
24. FUNERAL DIRECTOR Simmons Bros.		25a. REC'D BY REGISTRAR MAR 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S SIGNATURE	

04113

EXHIBIT OF DATA

04113

04113

04113

04113

04113

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04118

CERTIFICATE OF DEATH

04117

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE			c. LENGTH OF STAY IN 1b 1			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS				d. STREET ADDRESS 5418 WALTON AVE.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) EDWARD		First LIAM		Middle PAWLAK		4. DATE OF DEATH Month MARCH Day 22 Year 1967	
5. SEX MALE	6. COLOR OR RACE CAUC.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 FEBRUARY 67		9. AGE (In years lost birthday) yrs. 24	IF UNDER 1 YEAR Months 24 Days 24 Hours 24 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (County & State, or foreign country) PRINCE GEORGE'S, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HARRY J. PAWLAK				14. MOTHER'S MAIDEN NAME RUTH C. CHAPMAN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NA		17. INFORMANT RECORDS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 7730 IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO (b) Respiratory Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Sudden Death in Infancy							INTERVAL BETWEEN ONSET AND DEATH 8 Hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>22 March, 1967</u> to <u>22 March, 1967</u> that (I) (we) last saw the deceased alive on <u>22 March, 1967</u> , and that death occurred at <u>10:00 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <i>Herrick J. Cohen</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 22 March 1967	
22c. PHYSICIAN'S NAME (Type) HERRICK J. COHEN, CAPTAIN USAF MC				22d. ADDRESS USAF HOSPITAL ANDREWS AFB, WASH 25, DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/27/67		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY		23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR ROBERT E. WILHELM				ADDRESS 4308 SUITLAND RD. SUITLAND, MARYLAND		25a. REC'D BY REGISTRAR MAR 28 1967	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VALID

VALID

DATE

DATE

NAME

NAME

ADDRESS

ADDRESS

CITY

CITY

STATE

STATE

ZIP

ZIP

PHONE

PHONE

FAX

FAX

TELETYPE

TELETYPE

TELEFAX

TELEFAX

TELEMAIL

TELEMAIL

TELEVIDEO

TELEVIDEO

TELEAUDIO

TELEAUDIO

TELETEXT

TELETEXT

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05685

05685

FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 213 75th. Street	
3. NAME OF DECEASED (Type or print) First Middle Last Spencer H Payne		4. DATE OF DEATH Month Day Year 3 30 19 67	
5. SEX male	6. COLOR OR RACE negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 Nov. 1925
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Radio Dispatcher		10b. KIND OF BUSINESS OR INDUSTRY AAA	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Payne		14. MOTHER'S MAIDEN NAME Lillian Coleman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Catherine Payne		Address 213 75th St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 3-31-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/4/67	23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Ceme.	23d. LOCATION (City or Town) (County) (State) Maryland
24. FUNERAL DIRECTOR Stewart Funeral Home-4001 Benning Rd.		25a. REGISTRY REGISTRAR APR 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

2220

— — —

• • • • •

1
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04119		04118	
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier	
c. LENGTH OF STAY IN 1b 17 days		d. STREET ADDRESS 3604 Perry Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 74 Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Teresa Pelle		4. DATE OF DEATH Month Year Day March 16 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 Dec., 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	9. AGE (In years last birthday) 86 yrs.
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME Anthony Varrasse		14. MOTHER'S MAIDEN NAME Angela Rugero	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Albert DiCarlo (above address)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X Cerebral arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) OUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Recent pneumonia INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 28, 1967, to March 16, 1967, that (I) (we) last saw the deceased alive on March 16, 1967, and that death occurred 12:20 AM from the causes and on the date stated above.			
22a. SIGNATURE Don B. Cameron		22b. DATE SIGNED March 16, 1967	
22c. PHYSICIAN'S NAME (Type) Don B. Cameron, M.D.		22d. ADDRESS 3503 Perry St., Mt. Rainier, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/18/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City, town or county) (State) Washington, D.C.
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge	

04113

04113

Prince George

Prince George

Prince George

Mr. Kishan

17 days

17 days

3000 Fair Street

3000 Fair Street

18

18

18

18

18

18

18

18

18

18

18

18

18

18

18

18

04120

04119

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

6950

81150-

12 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04121

CERTIFICATE OF DEATH

04120

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Temple Hills, Maryland 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 5611-Old Temple Hills RD SE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle N. Last PORTER		4. DATE OF DEATH Month March Day 14th Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Jan. 25, 1915
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Washington Gas Light Co.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Washington, DC		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Madison C. Porter		14. MOTHER'S MAIDEN NAME Emma S. Baldwin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 577 07 7981	
17. INFORMANT Ruth M. Porter (Wife) Same as Item #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> DUE TO (b) <i>coronary arteriosclerosis</i> DUE TO (c) <i>Essential Hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Essential Hypertension</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/16, 1967, to 3/14, 1967, that (I) (we) lost saw the deceased alive on 3/9, 1967 and that death occurred at 3 P.M. from causes on and on the date stated above.			
22a. SIGNATURE <i>S. W. Nealon Jr.</i>		22b. DATE SIGNED Mar. 15-1967	
22c. PHYSICIAN'S NAME (Type) Dr. Stephen W. Nealon, Jr.		22d. ADDRESS 1746-K-St., N.W. Wash. D. C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Mar. 17-67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland, Maryland
24. FUNERAL DIRECTOR <i>Simmons Bros.</i>		25a. REC'D BY REGISTRAR MAR 16 1967	
ADDRESS Simmons Bros.-1661-Good Hope Rd SE Wash DC		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

04120

CONTINUED ON REVERSE

13140

But, super that information
around a certain business

11-11-77

11-11-77

11-11-77

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04122

CERTIFICATE OF DEATH

04121

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 2 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Manor				d. STREET ADDRESS 11419 Lund Place			
3. NAME OF DECEASED (Type or print) First Hannah Middle A. Last Powderly				4. DATE OF DEATH Month March Day 29 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1890		9. AGE (In years lost birthday) yrs. 76	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd Clerk		10b. KIND OF BUSINESS OR INDUSTRY Civil Service Comm.		11. BIRTHPLACE (County & State, or foreign country) Carbondale, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Powderly				14. MOTHER'S MAIDEN NAME Catherine Loftus			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 577-48-4633		17. INFORMANT Mrs. John C. Lynch		Address same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolus 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ulcerative Colitis 2 Years							INTERVAL BETWEEN ONSET AND DEATH 2 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 7, 1965 , to March 29, 1965 , that (I) was last saw the deceased alive on March 29, 1967 , and that death occurred at 6:10 a.m. from causes on and on the date stated above.							
22a. SIGNATURE Thomas F Collins				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/29/67	
22c. PHYSICIAN'S NAME (Type) Thomas F Collins, M.D.				22d. ADDRESS 622 H St. N.E. Washington, D.C. 20002			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-31-67		23c. NAME OF CEMETERY OR CREMATOR Mount Olivet		23d. LOCATION (City or Town) (County) (State) Washington, D. C.	
24. FUNERAL DIRECTOR Francis J. Collins				25a. REC'D BY REGISTRAR MAR 31 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

01110

EXHIBIT OF DEATH

01110

1. Name of Deceased: [illegible]
2. Date of Death: [illegible]
3. Place of Death: [illegible]
4. Cause of Death: [illegible]
5. Age at Death: [illegible]
6. Sex: [illegible]
7. Race: [illegible]
8. Occupation: [illegible]
9. Marital Status: [illegible]
10. Education: [illegible]
11. Religious Beliefs: [illegible]
12. Social History: [illegible]
13. Family History: [illegible]
14. Medical History: [illegible]
15. Mental History: [illegible]
16. Substance Use: [illegible]
17. Trauma History: [illegible]
18. Post-Mortem Examination: [illegible]
19. Autopsy Findings: [illegible]
20. Toxicology: [illegible]
21. Pathology: [illegible]
22. Radiology: [illegible]
23. Laboratory Tests: [illegible]
24. Other Findings: [illegible]
25. Signatures: [illegible]
26. Date of Report: [illegible]
27. Location of Report: [illegible]
28. Name of Reporting Officer: [illegible]
29. Title of Reporting Officer: [illegible]
30. Contact Information: [illegible]

FOR STATE
HEALTH DEPT

04123

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04122

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchelville		
c. LENGTH OF STAY IN IB DOA			d. STREET ADDRESS RTE. 1, Box 1118		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital					
3. NAME OF DECEASED (Type or print) First Middle Last James Ryan Proctor			4. DATE OF DEATH Month Day Year 3 24 19 67		
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-19-66	9. AGE (In years last birthday) yrs. 3 5	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Brown			14. MOTHER'S MAIDEN NAME Barbara Proctor		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Barbara Proctor Rt. 1 Box 1118		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 493X IMMEDIATE CAUSE (a) Undetermined (SDII) DUE TO Associated with pulmonary congestion, bilateral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) SDII and pulmonary atelectasis, focal DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED 3-25-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-28-67	23c. NAME OF CEMETERY OR CREMATORY Church Cemetery	23d. LOCATION (City or Town)	(County)	(State)
24. FUNERAL DIRECTOR ROLLINS FUNERAL HOME			25. REG'D BY REGISTRAR 4339 Hunt Pl., N. MAR 29 1967		
			25b. REGISTRAR'S SIGNATURE Charles Judge		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

SS110

SS110

11-11-11

11-11-11

11-11-11

X

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04124

CERTIFICATE OF DEATH

04123

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write-RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 8313 Bock Road	
3. NAME OF DECEASED (Type or print) S First Middle Last John P. C. Proctor		4. DATE OF DEATH Month Day Year March 4, 19 67	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/21/03
9. AGE (In years lost birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Ret.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Proctor		14. MOTHER'S MAIDEN NAME Elizabeth (Unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-16-2548	
17. INFORMANT Mary Helen Harley-Daughter		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, acute DUE TO (b) Acute Coronary Occlusion. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work ot work	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 2, 19 67, to March 4, 19 67, that (I) (we) last saw the deceased alive on March 4, 19 67, and that death occurred at 11:45 AM, from causes and on the date stated above.			
22a. SIGNATURE R. U. FRANCHI		22b. DATE SIGNED 3-6-67	
22c. PHYSICIAN'S NAME (Type) R. U. FRANCHI		22d. ADDRESS 7729 Finn's Lane, Lanham Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-8-67	
23c. NAME OF CEMETERY OR CREMATORY ST. PETERS		23d. LOCATION (City or Town) (County) (State) WALDORF Charles Md	
24. FUNERAL DIRECTOR ARCHART FUNERAL HOME INC		25a. REC'D BY REGISTRAR MAR 10 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

04134

04134

Prince George's

Marine

Prince George's

Marine

Marine

Marine

Marine

Prince George's

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

Marine

25b. REGISTRAR'S SIGNATURE

258. REGISTRAR'S SIGNATURE
Charles Judge

VR A15 (4)
15M 9/60

AS110

AS110

MAR 28 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04126

CERTIFICATE OF DEATH

04125

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 2 years, 2 mo.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Home, 5805 Queens Chapel Rd.		d. STREET ADDRESS 1126 Shepherd Street, N.E.	
3. NAME OF DECEASED (Type or print) First Middle Last Agnes Mary Pyne		4. DATE OF DEATH Month Day Year March 31 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 7, 1872
9. AGE (In years last birthday) 94 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Broderick Peterson		14. MOTHER'S MAIDEN NAME Agnes Krusa	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 579-62-6194	
17. INFORMANT Sacred Heart Home, Hyattsville, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure, acute (from coronary thrombosis) DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerosis, general		INTERVAL BETWEEN ONSET AND DEATH 1 hour Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from January, 1957 , to March 31, 1967 , that (I) was last saw the deceased alive on March 30, 1967 , and that death occurred at 3:45 p.m. from causes and on the date stated above.			
22a. SIGNATURE John F. Brennan Jr.		22b. DATE SIGNED March 31, 1967	
22c. PHYSICIAN'S NAME (Type) JOHN F. BRENNAN JR.		22d. ADDRESS 1034 PERRY ST. N.E. WASH. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-4-67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	23d. LOCATION (City or Town) (County) (State) Washington, D. C.
24. FUNERAL DIRECTOR WILLIAMS FUNERAL HOME		25a. REC'D BY REGISTRAR APR 3 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		25c. ADDRESS 3821 14th ST. N.W. WASH. D.C.	

05150

25140

971020 6:55

• *How to Use This Book*

• • • • •

NOTED: HEALTH BOARD, 2007, 11/11/07

5.

52

2014

2

10

Star 17

X.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841.

42-2-272

3

I

[

5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04127

CERTIFICATE OF DEATH

04126

| | | | | | | | |
|--|---------------------------|---|----------------------------|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Prince Georges | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland | | b. COUNTY
Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN TB
59 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hyattsville | | 16-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince Georges General Hospital | | | | d. STREET ADDRESS
4834 - 69th Place | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
William J. - Quigley | | First Middle Last | | 4. DATE OF DEATH
March 10, 1967 | | Month Day Year | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7/5/90 | | 9. AGE (In years lost birthday)
76 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Steam Fitter (Ret'd) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Delaware | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Frank Quigley | | | | 14. MOTHER'S MAIDEN NAME
Elizabeth Bridgeman | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
578-20-5876 | | 17. INFORMANT
Mrs. Bernard E. Zeimetz | | Address (same as #2) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>TERMINAL CA PANCREAS</u>
157X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>C METASTASIS TO BRAIN, LUNGS</u>
(c) <u>LIVER</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Months</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>66</u> , to <u>March 10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 10</u> , 19 <u>67</u> , and that death occurred at <u>8:00</u> M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Thomas G. Maloney</u> | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
March 10, 1967 | | | |
| 22c. PHYSICIAN'S NAME (Type)
Thomas G. Maloney | | 22d. ADDRESS
4814 - 71st Ave. Landover, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
3/13/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln | | 23d. LOCATION (City or Town) (County) (State)
Bladensburg, Maryland | |
| 24. FUNERAL DIRECTOR
ADDRESS
F.J. COLLINS 3821-14th ST. N.W. WASH. D.C. | | | | 25a. REC'D BY REGISTRAR
DATE
MAR 13 1967 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles J. J...</u> | |

2570-1-2003

(continued)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04128 CERTIFICATE OF DEATH 04127

| | | | |
|--|---------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>On Geo</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltville and</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING 15-2</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Even Eden Nursing Home</u> | | d. STREET ADDRESS <u>10710 Kimloch Rd</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>LORENDA</u> Last <u>RAND</u> | | 4. DATE OF DEATH Month <u>Mar</u> Day <u>25</u> Year <u>1967</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan 18, 1886</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Cambridge, VT</u> | |
| 13. FATHER'S NAME <u>FRANK N. MELENDY</u> | | 14. MOTHER'S MAIDEN NAME <u>CELIA L. STRONG</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u> | | 16. SOCIAL SECURITY NO. <u>008-03-1141</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
332X DUE TO <u>Cerebral & generalized</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Debridement</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>Feb 8 1967</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) (County) (State) <u>Laurel, Md</u> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb 8, 1967</u> to <u>Mar 25, 1967</u> , that (I) (we) last saw the deceased alive on <u>Mar 16, 1967</u> , and that death occurred at <u>4:15</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>W. L. Etienne</u> | | 22b. DATE SIGNED <u>3/25/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>W. L. ETIENNE</u> | | 22d. ADDRESS <u>College Park, Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u> | | 23b. DATE THEREOF <u>MAR 25, 1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>LEE FUNERAL HOME</u> | | 23d. LOCATION (City, town or county) (State) <u>WASH. DC.</u> | |
| 24. FUNERAL DIRECTOR <u>Harold S Wade</u> | | 25a. REC'D BY REGISTRAR <u>Samuel, MC</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Samuel, MC</u> | | DATE <u>MAR 27 1967</u> | |

DAISY

DAISY

1 Nov

Patience

Green Green Green Green

Mar 22

RAN

Elia

Elia

81

✓

W

F

General Thompson
Credited & approved
C. Thompson

ink

let 8 of Jan 27

Marie 27

W. E. Evans

3/12/07
Chicago, Ill.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04129

04128

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove covering papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|---|--|--|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Pro Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly, Md | | | c. LENGTH OF STAY IN lb
12 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hyattsville, Md. | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
74 Prince Georges General Hospital | | | | d. STREET ADDRESS
6504 Truman Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) William R Reid sr | | | First Middle Last | | 4. DATE OF DEATH Month March Day 23 Year 1967 | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug 14, 1911 | | 9. AGE (In years last birthday) 55 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
Thomas J Reid | | | 14. MOTHER'S MAIDEN NAME
Ettie M Orme | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) no (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
577 10 7255 | | 17. INFORMANT Address
Elinor B Reid Hyattsville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Carcinomatosis
1621 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Benign gastric Carcinoma
DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 15, 1967, to March 23, 1967, that (I) (we) last saw the deceased alive on March 22, 1967, and that death occurred at M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
 | | | | 22b. DATE SIGNED | | 22c. PHYSICIAN'S NAME (Type) A Deitz | |
| 22d. ADDRESS
Hyattsville, Md. | | | | 22e. MED. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Mar 25, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Colmar Manor Pro Geo Md. | |
| 24. FUNERAL DIRECTOR ADDRESS
F. Gasch's Sons Hyattsville, Md. | | | | 25a. REC'D BY REGISTRAR
MAR 27 1967 | | 25b. REGISTRAR'S SIGNATURE
 | |

02132

02132

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

04130

CERTIFICATE OF DEATH

04129

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Prince Geo.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Glenarden</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>16.1</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>8606 Hamlin Street</u> | | d. STREET ADDRESS
<u>8606 Hamlin</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Joseph H. Ridgley</u> | | 4. DATE OF DEATH
Month <u>3</u> Day <u>18</u> Year <u>1967</u> | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>Col</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>1875</u> |
| 9. AGE (In years last birthday)
<u>92</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>naug</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY
<u>-</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>D.C.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A</u> | | 13. FATHER'S NAME
<u>Robert Ridgley</u> | |
| 14. MOTHER'S MAIDEN NAME
<u>Sarah Green</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | |
| 16. SOCIAL SECURITY NO.
<u>579-246325</u> | | 17. INFORMANT
<u>Katie Ridgley</u> Address <u>8606 Hamlin St</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u>
DUE TO <u>Hyperbension</u>
DUE TO <u>Atherosclerosis</u>
DUE TO <u>1 day</u>
DUE TO <u>6 months</u>
DUE TO <u>1 yr</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 day</u>
<u>6 months</u>
<u>1 yr</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>19</u> o.m. p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 10, 1966</u> to <u>March 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>3-18-1967</u> , and that death occurred at <u>7:30 AM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>John G. Todd</u> | | 22b. DATE SIGNED
<u>3-18-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>John G. Todd M.D.</u> | | 22d. ADDRESS
<u>8 Rhode Island Ave, N.W.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF
<u>3-22-1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Harmony Memo. Park</u> | 23d. LOCATION (City or Town) (County) (State)
<u>7601 Shub. Rd. Landowne Md.</u> |
| 24. FUNERAL DIRECTOR
<u>Oscar Barnes</u> | | 25a. REC'D BY REGISTRAR
<u>Charles Judge</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | 25c. DATE
<u>MAR 27 1967</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00128

00128

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04131

Item #9 Film #3387 3/27/67 DC

CERTIFICATE OF DEATH

04130

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Pr. George's
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale
c. LENGTH OF STAY IN 1b 5 Min.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Pr. George's
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Beltsville
d. STREET ADDRESS 3700 Sellman Rd.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Katie Lillian Riley
4. DATE OF DEATH March 19 1967 | | 5. SEX Female
6. COLOR OR RACE W
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH April 27, 1903
9. AGE (In years last birthday) 63 yrs.
IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME ? Jordan
14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
16. SOCIAL SECURITY NO. -----
17. INFORMANT Address Dock M. Riley-Item # 2 | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
4201 DUE TO Generalized Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from 9 - 19, 1960, to 3 - 19, 1967, that (I) (we) last saw the deceased alive on 3 - 15, 1967, and that death occurred at 7 PM, from the causes and on the date stated above.
22a. SIGNATURE L.W. Malin
22b. DATE SIGNED 20 March, '67
22c. PHYSICIAN'S NAME (Type) L. W. Malin
22d. ADDRESS 4404 Queensbury Rd. Riverdale, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 3/23/67
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery
23d. LOCATION (City, town or county) (State) Rockville, Md. | | 24. FUNERAL DIRECTOR L. W. Malin
25a. REC'D BY REGISTRAR
25b. REGISTRAR'S SIGNATURE
MAR 23 1967 | |

051100

051100

051100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---------------------------|---|---|---|-----------------------------------|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 04132 | | | | | 04131 | | | | |
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | | c. LENGTH OF STAY IN 1b
3 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Landover | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince Georges General Hospital | | | | | d. STREET ADDRESS
3123 75th Ave. | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Rosa M Rivera | | | 4. DATE OF DEATH
Month Day Year
March 7 19 67 | | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
30 Oct., 1893 | | 9. AGE (In years last birthday)
73 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Porto Rico | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Victor Rivera | | | | | 14. MOTHER'S MAIDEN NAME
Maria A. | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO.
219 54 8830 | | 17. INFORMANT
T Mary Nieves | | | Address
Same as # 2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u>
4201
DUE TO
(b) <u>Myocardial Infarction</u>
DUE TO
(c) <u>Coronary Artery Disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Carcinoma of lung & pneumonia</u> | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3/4</u> , 19 <u>67</u> , to <u>3/7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/7</u> , 19 <u>67</u> , and that death occurred at <u>4:25 AM</u> , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<u>Edwin J. Jensen</u> | | | | | 22b. DATE SIGNED
3/7/67 | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Edwin J. Jensen | | | | | 22d. ADDRESS
Prince Geo. General Hosp., Cheverly, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | 23b. DATE THEREOF
3-9-1967 | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Wash. D.C.</u> | | 23d. LOCATION (City, town or county) (State)
<u>Wash. D.C.</u> | | |
| 24. FUNERAL DIRECTOR
<u>Matthew 131-11th St. S.E. D.C.</u> | | | | | 25a. REC'D BY REGISTRAR
MAR 8 1967 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

04131

04131

Prince Georges

Prince Georges

Landover

Landover

Landover

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

1953 1954

Prince Georges

Prince Georges

1953 1954

1953 1954

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04133

Item #8 Film #G387 4/5/67 DC

CERTIFICATE OF DEATH

04132

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN lb
10 days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Kentland | | 16-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George's General Hospital | | d. STREET ADDRESS
7624 Kilmer Street | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Joseph Rogers | | 4. DATE OF DEATH
Month Day Year
March 23 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
Cauc. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5-10-84/ 1883 |
| 9. AGE (In years last birthday)
83 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Foreman, Brick Co. | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
King George Co., Va. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John Rogers | | 14. MOTHER'S MAIDEN NAME
Catherine Trigger | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
6917 DECATUR RD ACF, Josenh L. Rogers HYATTSVILLE, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4201 Congestive Heart Failure
DUE TO
(b) Coronary Artery Disease
DUE TO
(c) Atrial Fibrillation
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Pneumonia | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 3-13 , 19 67 , to 3-23 , 19 67 ; that (I) (we) last saw the deceased alive on 3-23 , 19 67 , and that death occurred at 6:35 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Edwin J. Jensen | | 22b. DATE SIGNED
March 24, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Edwin J. Jensen, M.D. | | 22d. ADDRESS
Prince Georges General Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
3-27-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Grace | | 23d. LOCATION (City or Town) (County) (State)
King George Co., Virginia | |
| 24. FUNERAL DIRECTOR
F. Gasch's Sons 4739 B & T Ave, Hyattsville, Md. | | 25a. REC'D BY REGISTRAR
MAR 28 1967 | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

04133

04133

Prince George's County

10 days

Prince George's County Hospital

10 days

Male

10 days

10 days

10

Prince George's County Hospital

10 days

10 days

10 days

10 days

10 days

10 days

Prince George's County Hospital

10 days

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 04134 | | | | | 04133 | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Prince George
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Greenbelt
c. LENGTH OF STAY IN 1b
Unknown
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
3 B Ridge Road | | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Greenbelt,
d. STREET ADDRESS
3B Ridge Road
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Mabel Maria Rolph | | | | | 4. DATE OF DEATH
Month Day Year
March 9, 1967 | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
5-1-00 | | 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.
66 yrs. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
At Home | | 11. BIRTHPLACE (County & State, or foreign country)
Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Louis Jehle | | | | | 14. MOTHER'S MAIDEN NAME
Mary Elizabeth Wagner | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Samuel Rolph, 3B Ridge Rd. | | Address
Md. Greenbelt, | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis 1 month
1538
DUE TO
(b) Adenocarcinoma of colon
DUE TO
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
1 month | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| MEDICAL CERTIFICATION
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19
20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from October 13, 1966 , to March 9, 1967 , that (I) (we) last saw the deceased alive on March 6, 1967 , and that death occurred at 3:10 P.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
C. J. Houmann
22c. PHYSICIAN'S NAME (Type)
C. J. Houmann, M. D. | | | | | 22b. DATE SIGNED
3-9-67
22d. ADDRESS
4404 Queensbury Rd. Riverdale, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Mar. 13, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
George Washington Cemetery, Hyattsville, Md. | | 23d. LOCATION (City, town or county) (State) | | | |
| 24. FUNERAL DIRECTOR
W. W. Chambers Co. Riverdale Md. | | | | | 25a. REC'D BY REGISTRAR
MAR 13 1967
25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

04133

04133

3 E Ridge Road

Model

White

At Home

Housewife

Domestic

No

Unknown

Advertisement of color

Advertisement of color

J. J. Hannon, W. D.

W. D. Hannon, W. D.

Mar. 13, 1907 George Washington Cemetery, Alexandria, Va.

Mar. 13, 1907

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04135

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04134

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly 16-1 | |
| c. LENGTH OF STAY IN 1b
DOA | | d. STREET ADDRESS
6307 Joslyn Place | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George General Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Agnes Rooney | | 4. DATE OF DEATH
Month Day Year
3 7 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1 Feb. 1878 |
| 9. AGE (In years lost birthday)
89 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Ireland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Jeremiah O'Connor | | 14. MOTHER'S MAIDEN NAME
Margaret Curtin | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
577 07 7618D | |
| 17. INFORMANT
Joseph L. Rooney Same as # 2 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure
4200 DUE TO Arteriosclerotic heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____ | | INTERVAL BETWEEN ONSET AND DEATH
minutes
unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Diabetes - over 20 years. | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
John Kehoe M.D. | | 22. DATE SIGNED
3-8-67 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
3-10-1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | 23d. LOCATION (City or Town) (County) (State)
Suitland, Md | |
| 24. FUNERAL DIRECTOR
Robert A. Mattingly | | 25a. REC'D BY REGISTRAR
MAR 10 1967 | |
| 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | Address
121 1st St S Wash, D.C. | |

04132

04132

Prince George's

Prince George's

200

200

Prince George's

Prince George's

200

200

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

200

Prince George's

Prince George's

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04136

04135

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | | | c. LENGTH OF STAY IN IB
DOA | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George's Hospital | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Herman Vincent Root | | | | 4. DATE OF DEATH
Month Day Year
March 4 19 67 | | | |
| 5. SEX
male | | 6. COLOR OR RACE
white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
March 5, 1916 | |
| 9. AGE (In years lost birthday)
50 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | | 11. BIRTHPLACE (State or foreign country)
Baltimore | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Sheet Metal Worker | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Sheet Metal Contract. | | | |
| 13. FATHER'S NAME
Jessie Root | | | | 14. MOTHER'S MAIDEN NAME
? | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WWII | | | | 16. SOCIAL SECURITY NO.
218-07-2800 | | 17. INFORMANT
Marie J. Root Address Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure
4200 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease
DUE TO
(c) over 3 yrs. | | | | | | INTERVAL BETWEEN ONSET AND DEATH
minutes | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
John Kehoe, M.D. | | | | 22. DATE SIGNED
3-4-67 | | | |
| EXAMINER'S NAME (Type)
John Kehoe, M.D. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Riverdale, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
3/8/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
Bruzdinski Funeral Home | | | | ADDRESS
1407 Eastern Ave. | | 25a. REC'D BY REGISTRAR
MAR 7 1967 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

04130

04130

Island County

Island County

Island County

County

County

County (2)

Island County

Island County

Island County

Island County

Island County

Island County

Sheet Metal Worker

Sheet Metal Worker

Sheet Metal Worker

Island County

Island County

Island County

Island County

Island County

Island County

Island County

Island County

Island County

Island County

Island County

Island County

Island County

Island County

Island County

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04137

CERTIFICATE OF DEATH

04136

| | | | | | | | |
|--|----------------------------------|---|--|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>PRINCE GEORGES</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>P.R. GEO. CO.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>WEST HYATTSVILLE</u> | | c. LENGTH OF STAY IN IT
<u>12 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>HYATTSVILLE</u> | | 11/6/67 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>HYATTSVILLE NURSING HOME</u> | | | | d. STREET ADDRESS
<u>500 CHILLUM RD.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>LOUIS</u> Middle <u>BENJAMIN</u> Last <u>ROSENTHAL</u> | | | | 4. DATE OF DEATH
Month <u>MARCH</u> Day <u>16</u> Year <u>1967</u> | | | |
| 5. SEX
<u>MALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>MAY 1, 1913</u> | | 9. AGE (In years last birthday)
<u>53</u> yrs. | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>CLERK</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>FACTORY</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>HARTFORD-CONNECTICUT</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>SAMUEL ROSENTHAL</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>SCHUMAN, ROSE</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>047-10-8730</u> | | 17. INFORMANT
<u>ROBERT ROSENTHAL</u> | | Address <u>500 CHILLUM RD. HYATTSVILLE MD.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Malignant Glioblastoma</u>
DUE TO
(b) <u> </u>
DUE TO
(c) <u> </u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u>66</u> , to <u>3-16</u> , 19 <u>67</u> , that (I) (we) just saw the deceased alive on <u>3-15</u> 19 <u>67</u> and that death occurred at <u>9 A.</u> M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Gilbert B. Cushner</u> M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>3-16-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>GILBERT B. CUSHNER</u> | | | | 22d. ADDRESS
<u>11161 New Hampshire Ave. Silver Spring, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>March 20, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Rose Hill Cemetery</u> | | 23d. LOCATION (City or town) (County) (State)
<u>Rocky Hill, Conn.</u> | |
| 24. FUNERAL DIRECTOR
<u>Arthur Walters, 254 Carroll St. N.W. Wash. D.C.</u> | | | | 25. REC'D BY REGISTRAR
DATE <u>MAR 23 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

03130

10

25/05/2019 10:11

11/25/2014

Small black, Eucalypti

21501

1947-48 11/11/47

EX 81P1.1 YAM

37401 3-18-71

6744

7-25-57

130002

Rosenthal

[Faint handwritten signature]

CH-10 ROBERT ROSENTHAL

McIntyre + Associates

52-71-E

199

21-8

3-10-27

Philip F. Fennell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|---------------------------------------|--|---|--|---------------------------------|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 04138 | | | | | 04137 | | | | |
| 1. PLACE OF DEATH
a. COUNTY <i>Prince Georges</i> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <i>Md.</i> b. COUNTY <i>Pr. Geo. Co</i> | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Chesley</i> | | | c. LENGTH OF STAY IN 1b <i>D.O.A.</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>University Park 10-1</i> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Prince Georges General Hospital</i> | | | | | d. STREET ADDRESS <i>6905 40th Avenue</i> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <i>VICTOR</i> Middle <i>OWEN</i> Last <i>ROY</i> | | | | | 4. DATE OF DEATH Month <i>March</i> Day <i>26</i> Year <i>1967</i> | | | | |
| 5. SEX <i>Male</i> | | 6. COLOR OR RACE <i>White</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>Oct. 4, 1912</i> | | 9. AGE (In years last birthday) <i>54</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Federal Government</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Lept. of Ag. F.H.A.</i> | | 11. BIRTHPLACE (County & State, or foreign country) <i>Alabama</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Louis Roy</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>Mary Courtney</i> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Family of Deceased</i> Address <i>(same as #2)</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>4201 Coronary Occlusion</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i>
DUE TO (c) | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>5 minutes</i>
<i>9 years</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>1958</i> , to <i>Feb</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>Feb 27</i> 19 <i>67</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <i>Arthur B. Rosenbaum</i> M.O. | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <i>3/26/67</i> | | |
| 22c. PHYSICIAN'S NAME (Type) <i>ARTHUR B ROSENBAUM</i> | | | | | 22d. ADDRESS <i>2121 Pennsylvania Ave NW</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE THEREOF <i>March 29, 1967</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i> | | 23d. LOCATION (City, town or county) (State) <i>Montgomery Co. Md</i> | | | |
| 24. FUNERAL DIRECTOR <i>Arthur Walters</i> | | ADDRESS <i>254 Carroll St. N.W. W.C.</i> | | 25a. REC'D BY REGISTRAR <i>note: cleared by coroner</i> | | DATE <i>MAR 28 1967</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

04138

04138

104

Antennae of *Leptocryptus*
2 mm long

21-27

Antennae of Leptocryptus

28 Feb 67

21-27
Antennae of *Leptocryptus*

Antennae of *Leptocryptus*

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04138

CERTIFICATE OF DEATH

04138

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>PRINCE GEORGE'S</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREENBELT</u>
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREENBELT CONVALESCENT CENTER 1010 GREENBELT RD</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE'S</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREENBELT</u> 16-1
d. STREET ADDRESS <u>613 RIDGE ROAD</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>ALICE</u> First <u>SCHAEFFER</u> Middle Last
5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>CAUCASIAN</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DIVORCED <input type="checkbox"/> 9. AGE (In years lost birthday) <u>82</u> yrs. 10. IF UNDER 1 YEAR Months <u>11</u> Days <u>19</u> 11. IF UNDER 24 HRS. Hours <u>67</u> Min. | | 4. DATE OF DEATH Month <u>MAR</u> Day <u>11</u> Year <u>1967</u>
11. BIRTHPLACE (County & State, or foreign country) <u>PENNA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>
13. FATHER'S NAME <u>ALFRED H KUHN</u>
14. MOTHER'S MAIDEN NAME <u>MARY PETERS</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>
16. SOCIAL SECURITY NO. <u>UNKNOWN</u>
17. INFORMANT <u>PAUL A KUHN</u> Address <u>ROUTE 3 ALLENTOWN PA</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4200 Congestive heart failure</u>
DUE TO (b) <u>arteriosclerotic heart disease</u>
DUE TO (c) <u>year</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Oxley nephritis</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> P.m. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9-20-66</u> , 19 <u>67</u> , to <u>3-11-67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-10-67</u> , 19 <u>67</u> , and that death occurred at <u>2:08</u> P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>W.C. Weintraub</u>
22c. PHYSICIAN'S NAME (Type) <u>William C. Weintraub, M.D.</u> | | 22b. DATE SIGNED
22d. ADDRESS <u>115 Centerway, Greenbelt, Md. 20770</u>
22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>
23b. DATE THEREOF <u>3-15-1967</u>
23c. NAME OF CEMETERY OR CREMATORY <u>JORDON LUTHERAN CEM</u>
23d. LOCATION (City or Town) (County) (State) <u>GREENFIELD PA.</u> | | 24. FUNERAL DIRECTOR <u>W.W. Chambers Co. Riverdale, Md.</u>
25a. REC'D BY REGISTRAR <u>MAR 14 1967</u>
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04138

04138

SECTION 12 IN DEATH

Conspicuous heart failure
Anteriorly placed heart

Dysrhythmia

Mr. Whitman

3-10-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04140

CERTIFICATE OF DEATH

04139

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Prince George's</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Cheverly</i> | | | | c. LENGTH OF STAY IN 1b
<i>2 days</i> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<i>Prince George's General Hospital</i> | | | | d. STREET ADDRESS
<i>3723 Darnell Drive</i> | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<i>MAY V. SCHAVNICK</i> | | | | 4. DATE OF DEATH
Month Day Year
<i>March 10 1967</i> | | | |
| 5. SEX
<i>Female</i> | | 6. COLOR OR RACE
<i>White</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>6/13/03</i> | |
| 9. AGE (In years last birthday)
<i>63</i> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | 11. BIRTHPLACE (County & State, or foreign country)
<i>Wisconsin</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13. FATHER'S NAME
<i>Unknown</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>MARY MULLEN</i> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<i>NO</i> | | | | 16. SOCIAL SECURITY NO.
<i>NONE</i> | | 17. INFORMANT
<i>Andrew V. Schavnick, 3723 Donnell Dr.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
<i>1992 Cardiac failure</i>
DUE TO
(b) <i>Dehydration & malnutrition</i>
DUE TO
(c) <i>Widespread metastatic ca</i> | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>Immediate</i>
<i>1 wh</i>
<i>1 yr</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<i>Small bowel obstruction due to cancer</i> | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
<i>19</i> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>1/11/1967</i> to <i>3/10/1967</i> , that (I) (we) last saw the deceased alive on <i>3/10/1967</i> , and that death occurred at <i>11:30 A.M.</i> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>Kelvin L. Minchin</i> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
<i>KELVIN L. MINCHIN</i> | | | | 22d. ADDRESS
<i>6400 MARLBORO PIKE SE</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>CREMATION</i> | | 23b. DATE THEREOF
<i>3-14-1967</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>FORT LINCOLN</i> | | 23d. LOCATION (City, town or county) (State)
<i>Bladensburg Rd. P. George Md.</i> | |
| 24. FUNERAL DIRECTOR
<i>W.W. CHAMBERS CO. 517 N. B. St. WASHINGTON DC</i> | | | | 25a. REC'D BY REGISTRAR
<i>MAR 20 1967</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

04132

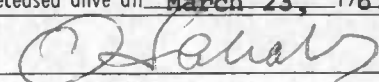

0510

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04141

CERTIFICATE OF DEATH

04140

| | | | | | | | | |
|--|--|--|---|---|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland b. COUNTY
Prince Georges | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | | c. LENGTH OF STAY IN 1b
20 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Mt. Rainier | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince Georges General Hospital | | | | d. STREET ADDRESS
3802 - 30th St. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 3. NAME OF DECEASED
(Type or print)
Charles Wm. Schellinger | | | | 4. DATE OF DEATH
Month March Day 23 Year 19 67 | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | B. DATE OF BIRTH
5/14/05 | | |
| 9. AGE (In years lost birthday)
61 yrs. | | IF UNDER 1 YEAR
Months _____ Days _____ | | IF UNDER 24 HRS.
Hours _____ Min. _____ | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Police | | | 10b. KIND OF BUSINESS OR INDUSTRY
Univ. Md. Police | | 11. BIRTHPLACE (County & State, or foreign country)
New Jersey | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Washington Schellinger | | | | 14. MOTHER'S MAIDEN NAME
Florence M Gates | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | | 16. SOCIAL SECURITY NO.
577289454 | | 17. INFORMANT
Mildred Schellinger Address
Mt. Rainier, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
DUE TO Atherosclerotic Cerebro-Vascular Disease
(b) Diabetes Mellitus
DUE TO Coronary Heart Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3-3-67
year
year | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to March 23, 1967 , that (I) (we) last saw the deceased alive on March 23, 1967 , and that death occurred at 3:30 M. from causes and on the date stated above. | | | | | | | | |
| 22a. SIGNATURE
 | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. PM DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
3-23-67 | | | |
| 22c. PHYSICIAN'S NAME (Type)
JOHANNES SAHAKYAN | | | 22d. ADDRESS
5813 LANDOVER Rd Chevy Chase | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE THEREOF
3-25- 67 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft Lincoln Crematory | | 23d. LOCATION (City or Town) (County) (State)
Colmar Manor, Md. | | |
| 24. FUNERAL DIRECTOR
Nalley Funeral Home | | | | ADDRESS
Mt Rainier, Md. | | 25a. REC'D BY REGISTRAR
DATE MAR 28 1967 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
 | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04140

04140

Prince Georges

Island

Prince Georges

Mr. Rainier

20 days

Overseas

2802 - 20th St.

Prince Georges General Hospital

23

28

March

Scandinavia

Mr.

Canada

Miss White

Miss White

X

March 28, 1941

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04142

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04141

| | | | | | | | |
|--|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | | | c. LENGTH OF STAY IN b
DOA | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George General Hospital | | | | d. STREET ADDRESS
7300 Good Luck Road | | | |
| 3. NAME OF DECEASED (Type or print) Conrad A. Schmiedicke (alias-James Afton) | | | | 4. DATE OF DEATH
Month 3 Day 9 Year 19 67 | | | |
| 5. SEX
male | | 6. COLOR OR RACE
white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
11-5-1915 | |
| 9. AGE (In years lost birthday)
51 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY
Automobiles | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Otto Schmiedicke | | 14. MOTHER'S MAIDEN NAME
Henrietta Steinbach | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
Yes | | 16. SOCIAL SECURITY NO.
WW 2, 216-09-5615 | | 17. INFORMANT
Address Mrs. Henrietta Schmiedicke, Dundalk Bldg. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure
4200 DUE TO Arteriosclerotic heartdisease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
minutes over 1 yr. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. _____ p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
John Kehoe, M.D. M.D. | | | | 22. DATE SIGNED
3-9-67 | | | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
3/13/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National | | 23d. LOCATION (City or Town) _____ (County) _____ (State) _____
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
Ulrich Funeral Home Dundalk, Md. | | | | 25a. REC'D BY REGISTRAR
DATE MAR 14 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

04110

04110

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04143

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04142

| | | | | | |
|--|------------------------------------|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE Maryland b. COUNTY Prince George's | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN 1b
DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hillcrest | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George's Hospital | | | d. STREET ADDRESS
5116 20th Avenue | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Karen Anne Schutawie | | | 4. DATE OF DEATH
Month Day Year
March 3 19 67 | | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
30 Nov. 1932 | | 9. AGE (In years lost birthday) yrs. 34 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY
AT HOME | | 11. BIRTHPLACE (State or foreign country)
ILLINOIS | |
| 13. FATHER'S NAME
VIRGIL GORDON | | | 14. MOTHER'S MAIDEN NAME
ERLYNNE HERRIOTT | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
579-42 1054 | | 17. INFORMANT
MUR TED SCHUTAWIE Address 5116 20th AVE HILLCREST HGS MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
976X IMMEDIATE CAUSE (a) Gun shot wound of head
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____
DUE TO (c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH
minutes |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Shot self at home. | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. AM 3-3-67 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | 20f. (City or town) (County) (State)
Same as #2 |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type)
John Kehoe, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Riverdale, Md. | | 22. DATE SIGNED
3-3-67 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
3-9-67 | 23c. NAME OF CEMETERY OR CREMATORY
BEDFORD CEM | | 23d. LOCATION (City or Town) (County) (State)
BEDFORD IOWA | |
| 24. FUNERAL DIRECTOR
W.W. Chambers Co. | | ADDRESS
RIVERDALE, MD | | 25a. REC'D BY REGISTRAR
MAR 8 1967 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

W.W. Chambers Co.

RIVERDALE, MD

MAR 8 1967

Charles Judge

04140

04140

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04144

CERTIFICATE OF DEATH

04143

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY
PRINCE GEORGE'S MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
VIRGINIA b. COUNTY
ARLINGTON | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ANDREWS AIR FORCE BASE | | c. LENGTH OF STAY IN 1b
6 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
USAF HOSPITAL ANDREWS | | d. STREET ADDRESS
1900 S. EADS ST. APT 214 | |
| 3. NAME OF DECEASED (Type or print)
JANE PAGE SHIPP | | 4. DATE OF DEATH
Month MARCH Day 1 Year 19 67 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
CAUCASIAN | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
26 NOV 1923 |
| 9. AGE (In years lost birthday)
43 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY
N/A | |
| 11. BIRTHPLACE (County & State, or foreign country)
ADAIR, KENTUCKY | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
SHREVE T. DAVIS | | 14. MOTHER'S MAIDEN NAME
KATHRYN PAGE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
UNKNOWN | |
| 17. INFORMANT
WARREN C. SHIPP-HUSBAND-SAME AS #2 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ANOXIA
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) CARCINOMA OF LUNG
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
5 DAYS
3 MONTHS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 23 FEB 1967 , to 1 MAR 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1 MAR 1967 , and that death occurred at 3:20M , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Charles D. Phelps, MD</i> | | 22b. DATE SIGNED
P.M. 1 MAR 67 | |
| 22c. PHYSICIAN'S NAME (Type)
CHARLES D. PHELPS, CAPT, USAF, MC | | 22d. ADDRESS
USAF HOSPITAL ANDREWS
ANDREWS AFB, WASHINGTON DC 20331 | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF
3-7-67 | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Hill | 23d. LOCATION (City or Town) (County) (State)
Fredericksburg Va |
| 24. FUNERAL DIRECTOR
W.W. Chambers & 577-11-57 SE Wash DC | | 25. REC'D BY REGISTRAR
DATE MAR 6 1967 | |
| 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

04113

DEPARTMENT OF STATE

04113

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

AMERICAN AIR FORCE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04145

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04144

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
o. COUNTY
Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE
Maryland b. COUNTY
Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN TB
DOA | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bowie | | d. STREET ADDRESS
13206 Idlewild Drive | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George General Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Fritz Juri Simon | | 4. DATE OF DEATH
Month Day Year
3 1 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
23 April 1886 |
| 9. AGE (In years lost birthday)
80 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Captain | | 10b. KIND OF BUSINESS OR INDUSTRY
Merchant marines | |
| 11. BIRTHPLACE (State or foreign country)
Estonia | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO.
044 12 1824 | |
| 17. INFORMANT
John F Simon | | Address
Bowie, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sarcoma of liver
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH
over 2 mo. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
John Kehoe M.D. | | 22. DATE SIGNED
3-1-67 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE THEREOF
March 2, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Ft Lincoln Crematory | | 23d. LOCATION (City or Town) (County) (State)
Golmar Manor Pro Geo Md. | |
| 24. FUNERAL DIRECTOR
F. Gasch's Sons | | ADDRESS
Hyattsville, Md. | |
| 25a. REC'D BY REGISTRAR
DATE MAR 6 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

01110

01110

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

George's

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1-66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

Item #7 Film #G386 3/10/67 pc

04146

CERTIFICATE OF DEATH

04145

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>PRINCE GEORGES</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Lanham</u> | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>90 Magnolia Gardens Nursing Home</u> | | | | d. STREET ADDRESS
<u>Bradbury Hazle, 16-1 4906-49th Ave.</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>May</u> Middle <u>Victoria</u> Last <u>Small</u> | | | | 4. DATE OF DEATH
Month <u>March</u> Day <u>3</u> Year <u>1967</u> | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>May 8, 1876</u> | |
| 9. AGE (In years lost birthday)
<u>90</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Registered Fitter</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Washington D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>John Collins</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Burroughs</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | | | 16. SOCIAL SECURITY NO.
<u>578-07-0751A</u> | | 17. INFORMANT
<u>Mrs. Blanch L. Collins</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>
4200 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ventricular Tachycardia</u>
DUE TO
(c) <u>A.S.H. ad.</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>3 P.M.</u> from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>William R. Greco</u> | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>3/3/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>WILLIAM R. GRECO</u> | | | | 22d. ADDRESS
<u>RIVERDALE, MD</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>3/7/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Cem</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Switzland Rd. P.D. Md</u> | |
| 24. FUNERAL DIRECTOR
<u>WW Chambers Inc.</u> | | | | 25a. REG'D BY REGISTRAR
<u>5555 Ga. Ave</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

MD.

24130

1992

FOR STATE
HEALTH DEPT.

04147

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04146

| | | | | | |
|---|----------------------------------|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | c. LENGTH OF STAY IN It DOA | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | | d. STREET ADDRESS Box 128 | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Agnes Helen Smith | | | 4. DATE OF DEATH
Month Day Year
3 8 19 67 | | |
| 5. SEX
Female | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4 July 1921 | | 9. AGE (In years last birthday) 45 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) D.C. | |
| 13. FATHER'S NAME William Joshua Abrams | | | 14. MOTHER'S MAIDEN NAME Sadie Belt | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT Address Sadie Abrams - mother | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Undetermined
795.5 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE John Kehoe M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED 3-9-67 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) 3-11-67 | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY Moses Cemetery | |
| 23d. LOCATION (City or Town) (County) (State) Arundel Co Md | | 23e. REC'D BY REGISTRAR 14 1967 | | 23f. REGISTRAR'S SIGNATURE John Kehoe | |
| 24. FUNERAL DIRECTOR ADDRESS H.S. Washington Sons 4925 Deane Ave NE | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

35120

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G386 3/16/67 pc

04148

CERTIFICATE OF DEATH

04147

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|--|---|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | | c. LENGTH OF STAY IN 1b
33 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Brentwood | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince Georges General Hospital | | | | d. STREET ADDRESS
4310 37th Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) James E Smith | | | | 4. DATE OF DEATH
Month March Day 5 Year 19 67 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
9 April 1918 | |
| 9. AGE (In years last birthday)
49 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Electrician | | 10b. KIND OF BUSINESS OR INDUSTRY
Electrician | | 11. BIRTHPLACE (County & State, or foreign country)
Penna. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Charles C. Smith | | | | 14. MOTHER'S MAIDEN NAME
Agnes Clancey | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO.
WW1 & Korea | | 17. INFORMANT
Florence F. Smith Same D2 wife | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis
DUE TO (b) Carcinoma of Pancreas, Primary
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH

 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb 1, 1967 to March 5, 1967 , that (I) (we) last saw the deceased alive on March 5, 1967 , and that death occurred at 7:30 AM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Benjamin S. Miller | | | | 22b. DATE SIGNED
3/6/67 | | 22c. PHYSICIAN'S NAME (Type)
Benjamin S. Miller | |
| 22d. ADDRESS

 | | | | 22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
3-9-67 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt Olivet Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Washington, D.C. | |
| 24. FUNERAL DIRECTOR
Lee Funeral Home 300-4th St. N.E. | | | | 25a. REC'D BY REGISTRAR
DAM | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

011117

011117

Prince Georges

Prince Georges

Prince Georges

Brantford

33 days

Chavari

W210 37th Street

Prince Georges 37th Street

W210 37th Street

W210 37th Street

W210 37th Street

W210 37th Street

W210 37th Street

W210 37th Street

W210 37th Street

W210 37th Street

Government of Prince Georges

Government of Prince Georges

X

W210 37th Street

W210 37th Street

W210 37th Street

W210 37th Street

W210 37th Street

W210 37th Street

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04149

CERTIFICATE OF DEATH

04148

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE D.C.
b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Glenn Dale (rural) | | c. LENGTH OF STAY IN 1b
2 mo. 21 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Glenn Dale Hospital | | d. STREET ADDRESS
1512 Marion St., N.W. | |
| 3. NAME OF DECEASED
(Type or print)
First Lorraine Middle J. Last Smith | | 4. DATE OF DEATH
Month March Day 25 Year 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
2-7-1913 |
| 9. AGE (In years last birthday)
54 yrs. | | 10. IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unemployed | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John W. Hubbert | | 14. MOTHER'S MAIDEN NAME
Lillie M. Mason | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
577-26-9779 | |
| 17. INFORMANT
Decedent | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction
DUE TO
(b) Arteriosclerotic heart disease
DUE TO
(c) Generalized arteriosclerosis | | | INTERVAL BETWEEN ONSET AND DEATH
24 hours
unknown
unknown |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Pulmonary tuberculosis; chronic alcoholism with Laennec cirrhosis | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (a) (this hospital) attended the deceased from 1--4--67 to 3-25 , 19 67 that (b) (we) last saw the deceased alive on 3-25 , 19 67 , and that death occurred at 12:30 A.M. from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
Moe Weiss | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
Moe Weiss, M.D. | | 22d. ADDRESS Glenn Dale Hospital
Glenn Dale, Maryland | |
| 23a. (BURIAL) CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF
Mar. 3, 1967 | 23c. NAME OF CEMETERY OR CREMATORY
Harmony Memorial | 23d. LOCATION (City or Town) (County) (State)
Lanham Md. |
| 24. FUNERAL DIRECTOR
Travis Funeral Home | | 25a. REC'D BY REGISTRAR
MAR 29 1967 | |
| ADDRESS
389 P.I. Ave., NW | | 25b. REGISTRAR'S SIGNATURE
Charles J. J... | |

01148

01149

C.C.

Glenn Dale

2 mo. 21 days Washington

Glenn Dale (rural)

1512 Madison St., N.W.

Glenn Dale Hospital

March

Smith

Foraine

2-7-1917

Waters

Waters

USA

Wesley

Unrecovered

William M. Mason

John W. Hubbard

Recovery

577-24-0748

No

Acute myocardial infarction

Arteriosclerotic heart disease

Generalized arteriosclerosis

Primary tuberculosis; chronic fibrosis with tubercle formation

2-22

2-22

2-22

Glenn Dale Hospital

Glenn Dale, Maryland

Glenn Dale, N.D.

MAR 9 1917

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04150

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04149

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b DOA | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Wilbur Middle A Last Smith | | 4. DATE OF DEATH Month 3 Day 26 Year 19 67 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 15 June 1907 |
| 9. AGE (In years last birthday) 59 yrs. | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAXI CAB DRIVER | | 10b. KIND OF BUSINESS OR INDUSTRY DIAMOND CAB CO. | |
| 11. BIRTHPLACE (State or foreign country) WASHINGTON D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME HARTWELL D. SMITH | | 14. MOTHER'S MAIDEN NAME UNKNOWN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES PEACE TIME | | 16. SOCIAL SECURITY NO. — | |
| 17. INFORMANT MRS. BERTHA F. SMITH | | Address 5620 HAMILTON MANOR DRIVE HYATTSVILLE, MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure
4200 DUE TO Arteriosclerotic heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH minutes over 2 yrs. |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe M.D. | | 22. DATE SIGNED 3-27-67 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 3-29-67 | 23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEM. | 23d. LOCATION (City or Town) (County) (State) BLADENSBURG, MD. |
| 24. FUNERAL DIRECTOR W.W. CHAMBERS Co. RIVERDALE, MD. | | 25a. REC'D BY REGISTRAR MAR 29 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

04150

04150

atmospheric

atmospheric

atmospheric

atmospheric

atmospheric

atmospheric

atmospheric

atmospheric

atmospheric

atmospheric

atmospheric

atmospheric

atmospheric

atmospheric

atmospheric

atmospheric

x

x

x

x

04150

04150

x

x

x

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04151

CERTIFICATE OF DEATH

04150

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>NONE</u> b. COUNTY <u>NONE</u> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>DISTRICT HGTS</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>WASHINGTON D.C.</u> 47.3 | |
| c. LENGTH OF STAY IN 1b
<u>3 MONTHS</u> | | d. STREET ADDRESS
<u>3039- QUE ST NW.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>REGENT NURSING HOME - 8100 MARLBORO</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) First <u>A.D.A.</u> Middle <u>C.</u> Last <u>SMOOT</u> | | 4. DATE OF DEATH Month <u>MARCH</u> Day <u>17</u> Year <u>1967</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>FEB 17, 1895</u> 72 yrs. |
| 9. AGE (In years last birthday) | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | 11. BIRTHPLACE (County & State, or foreign country)
<u>ILLINOIS</u> |
| 10b. KIND OF BUSINESS OR INDUSTRY
<u>AT HOME</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A</u> | |
| 13. FATHER'S NAME
<u>UNKNOWN</u> | | 14. MOTHER'S MAIDEN NAME
<u>UNKNOWN</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>577-07-18632</u> | |
| 17. INFORMANT <u>LEORA M. PENNYPACKER</u> | | Address <u>3039-QUE ST NW.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u>
<u>464X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombophlebitis & bronchial asthma</u>
DUE TO (c) <u>Fractured hip w/ Pin</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>C.H.F.</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-13-</u> , 19 <u>67</u> , to <u>3-17-</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>3-17</u> , 19 <u>67</u> , and that death occurred at <u>11:50 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>MARK H. PIVOR MD</u> | | 22b. DATE SIGNED
<u>3-17-67</u> | 22c. PHYSICIAN'S NAME (Type)
<u>MARK H. PIVOR MD</u> |
| 22d. ADDRESS
<u>7505 AVON CT, WASH. DC 31</u> | | 22e. REC'D BY REGISTRAR
<u>MAR 20 1967</u> | |
| 22f. REGISTRAR'S SIGNATURE
<u>J. Charles Judge</u> | | 22g. REGISTRAR'S NAME
<u>J. Charles Judge</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>3/27/1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>ARLINGTON NAT'L</u> |
| 23d. LOCATION (City or Town)
<u>ARLINGTON, VA.</u> | | 23e. (County) (State) | |
| 24. FUNERAL DIRECTOR
<u>W.W. CHAMBERS Co -</u> | | ADDRESS
<u>WASHINGTON D.C.</u> | |

04150

REMITTANCE OF DEBIT

04151

04152

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

04152

CERTIFICATE OF DEATH

04151

| | | | | | | | |
|---|------------------------------|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Riverdale</u> | | | | c. LENGTH OF STAY IN 1b
<u>2 Days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hyattsville</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Eugene Ieland Memorial Hospital</u> | | | | d. STREET ADDRESS
<u>8201 14th Avenue</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
<u>INFANT</u> <u>SOUTHARD</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>3</u> <u>30</u> <u>1967</u> | | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>3-28-67</u> | | 9. AGE (In years last birthday)
<u>0</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min.
<u>0</u> <u>2</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>none CHILD</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>none</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Prince Georges co., Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>Ronald Thomas Southard</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Collette Gilberte Langis</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>none</u> | | 17. INFORMANT
<u>MR RAYMOND LANGIS, 5109 Address 704 PE HYATTSVILLE, MD</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Anencephaly</u>
<u>750X</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO
(c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3-28</u> , 19 <u>67</u> , to <u>3-31</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-30</u> , 19 <u>67</u> , and that death occurred at <u>3:10 AM</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>D. R. Purdie</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>3-30-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>D. R. PURDIE, M.D.</u> | | | | 22d. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>3-31-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>GATE OF HEAVEN</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>WHEATON MARYLAND.</u> | |
| 24. FUNERAL DIRECTOR
<u>W.W. Chamber</u> | | | | 25a. REC'D BY REGISTRAR
<u>APR 4 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

VR A15 (4)
20 M 1/66

7-332955

12120

3520

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04153

CERTIFICATE OF DEATH

04152

| | | | | | | | | | | |
|--|----------------------------------|---|--|--|--|--|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Prince Georges | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN 1b
20 days | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland | | b. COUNTY
Prince Georges | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince Georges General Hospital | | | | d. STREET ADDRESS
3611 Cooper Lane | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED
(Type or print)
Elvia Renfrow | | First Middle Last
Stokes | | 4. DATE OF DEATH
March 10, 1967 | | Month Day Year | | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8/1/09 | | 9. AGE (In years lost birthday)
57 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | | 11. IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (County & State, or foreign country)
Johnston Co., N.C. | | | 12. CITIZEN OF WHAT COUNTRY
U.S.A. | | |
| 13. FATHER'S NAME
William H. Renfrow | | | | 14. MOTHER'S MAIDEN NAME
Luria Stancil | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
no | | | 16. SOCIAL SECURITY NO.
578 42 4306 | | 17. INFORMANT
James David Stokes | | | | Address
Same as #2 (husband) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis, ACUTE
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
DUPLICATE TO Arteriosclerotic Heart Disease
(b) 5 yrs
(c) | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
12 hrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from July , 1959, to 3/10 , 1967, that (I) (we) last saw the deceased alive on 3/10 , 1967, and that death occurred at 2:45 A.M., from causes and on the date stated above. | | | | | | | | | | |
| 22a. SIGNATURE
<i>Norman Donat Comeau</i> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
3/10/67 | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Norman Donat Comeau, M.D. | | | | 22d. ADDRESS
3503 Perry St., Mt. Rainier, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
3/13/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Stancil Church Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Kenley Johnston N.C. | | | | |
| 24. FUNERAL DIRECTOR
Francis Gasch's Sons | | | | ADDRESS
Hyattsville, Md. | | 25a. REC'D BY REGISTRAR
13 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04152

STATEMENT OF DEATH

04152

James George

Married

James George

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

(Married) as above as in (Married)

(Married) as above as in (Married)

(Married) as above as in (Married)

(Married) as above as in (Married)

(Married) as above as in (Married)

(Married) as above as in (Married)

(Married) as above as in (Married)

(Married) as above as in (Married)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

04154

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04153

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Pr. George</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Suitland</u> | | c. LENGTH OF STAY IN 1b
<u>6 months</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Comp Springs, Md.</u> | | 16-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Suitland Nursing Home Suitland Md</u> | | d. STREET ADDRESS
<u>7309 Coalbridge Rd. 20031</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Bessie E. Talbert</u> | | 4. DATE OF DEATH
Month <u>March</u> Day <u>13</u> Year <u>19 67</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Oct 19, 1888</u> |
| 9. AGE (In years last birthday)
<u>78</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Domestic</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>George Judge</u> | | 14. MOTHER'S MAIDEN NAME
<u>Lena Schmidt</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>Darnel Talbert</u> | | Address
<u>7309 Coalbridge Rd. Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4200 Congestive Heart Failure</u>
DUE TO (b) <u>Arteriosclerotic Heart disease</u>
DUE TO (c) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Mar 13, 1966</u> to <u>3/13/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/13/67</u> , 19 <u>67</u> , and that death occurred at <u>10:30 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>J. H. Thibadeau</u> | | 22b. DATE SIGNED
<u>14 MAR 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Dr. J. H. Thibadeau</u> | | 22d. ADDRESS
<u>3112 Alabama Ave., S.E. Wash. D.C.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>March 16-67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Oedar Hill Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Suitland, Maryland</u> | |
| 24. FUNERAL DIRECTOR
<u>Simmons Bros. Funeral Home</u> | | 25a. REC'D BY REGISTRAR
<u>15 MAR 1967</u> | |
| ADDRESS
<u>1661-Gd. Hope Rd. SE</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

04153

OFFICE OF THE SECRETARY OF THE ARMY

04153

| | | | | | |
|------------------------|--|------------------------|--|------------------------|--|
| 1. NAME OF THE OFFICER | | 2. GRADE | | 3. BRANCH | |
| 4. TITLE | | 5. DUTY STATION | | 6. DATE OF PROMOTION | |
| 7. DATE OF PROMOTION | | 8. DATE OF PROMOTION | | 9. DATE OF PROMOTION | |
| 10. DATE OF PROMOTION | | 11. DATE OF PROMOTION | | 12. DATE OF PROMOTION | |
| 13. DATE OF PROMOTION | | 14. DATE OF PROMOTION | | 15. DATE OF PROMOTION | |
| 16. DATE OF PROMOTION | | 17. DATE OF PROMOTION | | 18. DATE OF PROMOTION | |
| 19. DATE OF PROMOTION | | 20. DATE OF PROMOTION | | 21. DATE OF PROMOTION | |
| 22. DATE OF PROMOTION | | 23. DATE OF PROMOTION | | 24. DATE OF PROMOTION | |
| 25. DATE OF PROMOTION | | 26. DATE OF PROMOTION | | 27. DATE OF PROMOTION | |
| 28. DATE OF PROMOTION | | 29. DATE OF PROMOTION | | 30. DATE OF PROMOTION | |
| 31. DATE OF PROMOTION | | 32. DATE OF PROMOTION | | 33. DATE OF PROMOTION | |
| 34. DATE OF PROMOTION | | 35. DATE OF PROMOTION | | 36. DATE OF PROMOTION | |
| 37. DATE OF PROMOTION | | 38. DATE OF PROMOTION | | 39. DATE OF PROMOTION | |
| 40. DATE OF PROMOTION | | 41. DATE OF PROMOTION | | 42. DATE OF PROMOTION | |
| 43. DATE OF PROMOTION | | 44. DATE OF PROMOTION | | 45. DATE OF PROMOTION | |
| 46. DATE OF PROMOTION | | 47. DATE OF PROMOTION | | 48. DATE OF PROMOTION | |
| 49. DATE OF PROMOTION | | 50. DATE OF PROMOTION | | 51. DATE OF PROMOTION | |
| 52. DATE OF PROMOTION | | 53. DATE OF PROMOTION | | 54. DATE OF PROMOTION | |
| 55. DATE OF PROMOTION | | 56. DATE OF PROMOTION | | 57. DATE OF PROMOTION | |
| 58. DATE OF PROMOTION | | 59. DATE OF PROMOTION | | 60. DATE OF PROMOTION | |
| 61. DATE OF PROMOTION | | 62. DATE OF PROMOTION | | 63. DATE OF PROMOTION | |
| 64. DATE OF PROMOTION | | 65. DATE OF PROMOTION | | 66. DATE OF PROMOTION | |
| 67. DATE OF PROMOTION | | 68. DATE OF PROMOTION | | 69. DATE OF PROMOTION | |
| 70. DATE OF PROMOTION | | 71. DATE OF PROMOTION | | 72. DATE OF PROMOTION | |
| 73. DATE OF PROMOTION | | 74. DATE OF PROMOTION | | 75. DATE OF PROMOTION | |
| 76. DATE OF PROMOTION | | 77. DATE OF PROMOTION | | 78. DATE OF PROMOTION | |
| 79. DATE OF PROMOTION | | 80. DATE OF PROMOTION | | 81. DATE OF PROMOTION | |
| 82. DATE OF PROMOTION | | 83. DATE OF PROMOTION | | 84. DATE OF PROMOTION | |
| 85. DATE OF PROMOTION | | 86. DATE OF PROMOTION | | 87. DATE OF PROMOTION | |
| 88. DATE OF PROMOTION | | 89. DATE OF PROMOTION | | 90. DATE OF PROMOTION | |
| 91. DATE OF PROMOTION | | 92. DATE OF PROMOTION | | 93. DATE OF PROMOTION | |
| 94. DATE OF PROMOTION | | 95. DATE OF PROMOTION | | 96. DATE OF PROMOTION | |
| 97. DATE OF PROMOTION | | 98. DATE OF PROMOTION | | 99. DATE OF PROMOTION | |
| 100. DATE OF PROMOTION | | 101. DATE OF PROMOTION | | 102. DATE OF PROMOTION | |

1921

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04155

CERTIFICATE OF DEATH

04154

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Prince Georges
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
D.C.
b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Glenn Dale (rural) | | c. LENGTH OF STAY IN 1b
4 mos 17 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Glenn Dale Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Leroy Tarlton | | 4. DATE OF DEATH
Month Day Year
March 11 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/16/1910 |
| 9. AGE (In years last birthday) yrs.
56 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Maintenance Man | | 10b. KIND OF BUSINESS OR INDUSTRY
- - - | |
| 11. BIRTHPLACE (County & State, or foreign country)
Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Joe Tarlton | | 14. MOTHER'S MAIDEN NAME
Louise Sims | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No - - - | | 16. SOCIAL SECURITY NO.
578-24-8964 | |
| 17. INFORMANT
Decedent | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchogenic carcinoma, right lung, with general- 4 mo.
DUE TO ized metastases
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Bronchial biopsies 11/4/66 and 11/14/66 | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (this hospital) attended the deceased from 10/25 , 19 66 , to 3/11 , 19 67 , that (we) lost saw the deceased alive on 3/11 , 19 67 , and that death occurred at 6:25 P , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Moe Weiss | | 22b. DATE SIGNED
3/11/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Moe, Weiss, M.D. | | 22d. ADDRESS
Glenn Dale Hospital
Glenn Dale, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
3/17/67 | 23c. NAME OF CEMETERY OR CREMATORY
St. Paul Methodist | 23d. LOCATION (City or Town) (County) (State)
Oxon Hill, Md. |
| 24. FUNERAL DIRECTOR
ROBERT G. MASON FUN. HOME | | 25a. REC'D BY REGISTRAR
SE MAR 17 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

04154

RECEIVED 10 10 1943

04155

STACE GEORGE

Glenn Dale (mail)

Glenn Dale Hospital

Leroy

Male Negro

Maintenance Man

Los Angeles

No

Washington

1225 Capital St., S.W.

Tarleton

SALE/1943

Washington, D.C.

Louisiana

570-1-5500

RECEIVED 10 10 1943

RECEIVED 10 10 1943

RECEIVED 10 10 1943

3/11

Moore, Walter, M.D.

Glenn Dale Hospital
Glenn Dale, Maryland

3/11/43

7
8

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

99

2

2

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04156

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04155

| | | | | | | | |
|--|----------------------------------|---|--|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | | | c. LENGTH OF STAY IN b
DOA | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George General Hospital | | | | d. STREET ADDRESS
6210 Shadyside Avenue | | | |
| 3. NAME OF DECEASED
(Type or print) Horace Stanley Taylor | | | | 4. DATE OF DEATH
Month 3 Day 8 Year 1967 | | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9-1-1901 | 9. AGE (In years lost birthday)
65 yrs. | 10. IF UNDER 1 YEAR
Months Days Hours Min. | | 11. IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Goldthwaite, Kansas | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO.
WW 1 579-32-5763 | | 17. INFORMANT
Inez W. Taylor | | Address
Same as #2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
4200 IMMEDIATE CAUSE (a) Heart failure
DUE TO Arteriosclerotic heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
minutes
unknown |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
John Kehoe M.D. | | | | 22. DATE SIGNED
3-8-67 | | | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF
3-11-1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | 23d. LOCATION (City or Town) (County) (State)
Suitland, Maryland | |
| 24a. FUNERAL DIRECTOR
Robert A. Mattingly | | | | 25a. REC'D BY REGISTRAR
MAR 10 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |
| ADDRESS
131 11th St S.E. Washington, D.C. | | | | | | | |

04155

04156

Trinity Episcopal

St. Paul's

Trinity Episcopal

Trinity Episcopal

Trinity Episcopal

Trinity Episcopal

Trinity Episcopal

Trinity Episcopal

Trinity Episcopal

Trinity Episcopal

Trinity Episcopal

Trinity Episcopal

Trinity Episcopal

Trinity Episcopal

Trinity Episcopal

1
M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04157

CERTIFICATE OF DEATH

04156

| | | | | | | | |
|---|----------------------------------|---|--|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George Co.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland.</u> b. COUNTY <u>Prince George</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Clinton</u> | | | c. LENGTH OF STAY IN 1b
<u>2-17-67</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Camp Springs</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Pineview Gardens Health Care Center</u> | | | | d. STREET ADDRESS
<u>6621 Pots Lane</u> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>WALTER O TAYLOR</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>MARCH 6 19 67</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
<u>11-3-1886</u> | | 9. AGE (In years last birthday)
<u>80</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Rockingham Co. Va.</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Wm. Franklin Taylor</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Mary Ross</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>281-18-1514</u> | | 17. INFORMANT
<u>Arthur Taylor</u> | | Address
<u>Camp Springs Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4200 Vascular collapse</u>
DUE TO (b) <u>Arteriosclerotic heart disease</u>
DUE TO (c) <u>senility</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 days 6 min</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2/27</u> , 19 <u>67</u> to <u>3-6</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>3-6</u> , 19 <u>67</u> , and that death occurred at <u>3:30 P.M.</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Alfred R. Lapin</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>3/6/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>ALFRED R. LAPIN</u> | | | | 22d. ADDRESS
<u>QUINTON, MD</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>3/9/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Carman Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Gomer Ohio</u> | |
| 24. FUNERAL DIRECTOR
<u>Lee Funeral Home, Washington, D. C.</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>MAR 10 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

04155

CENTRAL OF MARY

04155

May 10 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04158

CERTIFICATE OF DEATH

04157

| | | | | | |
|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Pr. Geo. | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland | | b. COUNTY
Pr. Geo. 16.1 | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN ID
3 1/2 days | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
5506--Old Branch Ave., Camp Springs | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Prince George General Hospital | | d. STREET ADDRESS
5506--Old Branch Ave., SE | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First
WILLIAM | | Middle
A. | | Last
TAYLOR Sr. | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
July 15--1904 | | 9. AGE (In years last birthday)
62 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Meat Cutter Briggs Meat Co. | | 10b. KIND OF BUSINESS OR INDUSTRY
Virginia | | 11. BIRTHPLACE (County & State, or foreign country)
12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Julian H. Taylor | | 14. MOTHER'S MAIDEN NAME
Lillie Mae Jenkins | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
579 01 9057 | | 17. INFORMANT
Doris G. Taylor (Wife) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 3561
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) 3561
(c) AMYOTROPIC LATERAL SCLEROSIS | | INTERVAL BETWEEN ONSET AND DEATH
4 days
5 yrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 3/29, 1967 to 3/28, 1967, that (I) (we) last saw the deceased alive on 3/28, 1967, and that death occurred at 10:15 AM, from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
Dr. Norman D. Comeau | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
Mar. 28--1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Norman D. Comeau | | 22d. ADDRESS
3503--Perry St., Mt. Rainier, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Mar. 31-67 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | |
| 23d. LOCATION (City, town or county)
Suitland, Maryland | | 23e. REC'D BY REGISTRAR
MAR 29 1967 | | | |
| 24. FUNERAL DIRECTOR
Simmons Bros. | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

04158

04158

1017
AM

MAR 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04159

CERTIFICATE OF DEATH

04158

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN 1b
4 hr | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince Georges General Hospital | | d. STREET ADDRESS
5405 Detroit Ave. | |
| 3. NAME OF DECEASED (Type or print)
First Baby Middle Girl Last Thomas | | 4. DATE OF DEATH
Month 28 Day March Year 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12 March 1967 |
| 9. AGE (In years last birthday) yrs.
4 | | 10. IF UNDER 1 YEAR
Months 4 Days 11 Hours 11 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
Hollie Thomas | | 14. MOTHER'S MAIDEN NAME
Ramona Elizabeth Green | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral Aneurysms
DUE TO (b) Prenatally (1200 gms)
DUE TO (c) 7625
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (a) (this hospital) attended the deceased from March 12, 1967 , to March 12, 1967 , that (I) (we) last saw the deceased alive on March 12, 1967 , and that death occurred at 7:15 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Andrew G. Aronfy | | 22b. DATE SIGNED
March 14, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Andrew G. Aronfy, M.D. | | 22d. ADDRESS
Prince Georges General Hospital, Cheverly | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | 23b. DATE THEREOF
3/25/67 | 23c. NAME OF CEMETERY OR CREMATORY
Prince George's Gen Hosp | 23d. LOCATION (City or Town) (County) (State)
Cheverly PG Maryland |
| 24. FUNERAL DIRECTOR
Harry W. Penn, Jr., Admin., Cheverly, Maryland | | 25a. REC'D BY REGISTRAR
MAR 28 1967 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

7-225070

04123

CERTIFICATE OF DEATH

04128

Presumptive (1900)
Alcohol Collection

George H. [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04160

04159

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland b. COUNTY
Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN 1b
DOA | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George General Hospital | | d. STREET ADDRESS
Bladensburg 16-1 | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Earnest Joseph Thomas | | 4. DATE OF DEATH
Month Day Year
3 2 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9-24-1904 |
| 9. AGE (In years last birthday) yrs.
62 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Guard | | 10b. KIND OF BUSINESS OR INDUSTRY
College | |
| 11. BIRTHPLACE (State or foreign country)
Washington D C | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
William G. Thomas | | 14. MOTHER'S MAIDEN NAME
Resina Wege | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
578 12 2403 | |
| 17. INFORMANT
Maude V Thomas | | Address
Bladensburg, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure
DUE TO Arteriosclerotic heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH
minutes
unknown |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Pulmonary emphysema - over 10 years. | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
John Kehoe M.D. | | 22. DATE SIGNED
3-2-67 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. | | Address (Street, city, town, or county)
Riverdale, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
March 6, 1967 | 23c. NAME OF CEMETERY OR CREMATOR
Prospect Hill Cemetery | 23d. LOCATION (City or Town) (County) (State)
Washington D. C. |
| 24. FUNERAL DIRECTOR
F. Gasch's Sons. | | ADDRESS
Hyattsville, Md. | |
| 25a. REC'D BY REGISTRAR
DATE MAR 6 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

04150

04150

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04161

CERTIFICATE OF DEATH

04160

| | | | | | | | |
|---|------------------------------|---|-------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges
MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE D. C.
b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Glenn Dale (rural) | | | | c. LENGTH OF STAY IN 1b
1 yr., 4 mos. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Glenn Dale Hospital | | | | d. STREET ADDRESS
1510 P St., N. W. | | | |
| 3. NAME OF DECEASED (Type or print)
First Jennie Middle -- Last Thomas | | | | 4. DATE OF DEATH
Month 3 Day 8 Year 19 67 | | | |
| 5. SEX
F | 6. COLOR OR RACE
N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9/7/1900 | | 9. AGE (In years lost birthday)
66 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
-- | | 11. BIRTHPLACE (County & State, or foreign country)
Halls Hills, Va. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Charles Webster | | | | 14. MOTHER'S MAIDEN NAME
Alice (?) | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
unknown | | 17. INFORMANT
Decedent | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
583X IMMEDIATE CAUSE (a) Bronchopneumonia
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Crack of liver, etiology undetermined, with practically complete destruction of the right lobe of the liver
DUE TO (c) Generalized arteriosclerosis; rheumatoid arthritis | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 days

1 yr. 4mo. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Generalized arteriosclerosis; rheumatoid arthritis | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. _____ p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11/3/ , 19 65 , to 3/8/ , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3/8/ , 19 67 , and that death occurred at 2:15 P.M. , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Moe Weiss | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
3/8/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Moe Weiss, M. D. | | | | 22d. ADDRESS
Glenn Dale Hospital
Glenn Dale, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
B | | 23b. DATE THEREOF
3/16/67 | | 23c. NAME OF CEMETERY OR CREMATORY
HARMONY | | 23d. LOCATION (City or Town) (County) (State)
MARYLAND | |
| 24. FUNERAL DIRECTOR
UNIVERSAL F.H.S. 16 H. STONE | | | | 25a. REC'D BY REGISTRAR
DATE MAR 17 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

04180

04181

Prince George

Dr. C.

Glenn Dale (rural)

1 yr. 4 mos.

Washington

Glenn Dale Hospital

1500 F St., N. W.

Leone

Thomas

2

M

66

0/1/100

X

X

Housewife

Palis Mills, Va.

USA

Charles Webster

Alber (?)

Incident

unlabeled

No

3 days

atrophied

Generalized arteriosclerosis, rheumatic arthritis
complete destruction of the right lobe of the liver
tumor of liver, extensive, with practically
1 yr. 4 mos.

11/1/100 1/1/100 1/1/100

1/1/100

Non-Union, N. D.

Glenn Dale Hospital
Glenn Dale, Md.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #11 Infor. taken from birth cert. pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT

04162

04161

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
o. COUNTY
Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE
Maryland b. COUNTY
Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN 1b
DOA | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George General Hospital | | d. STREET ADDRESS
Brandywine
Rt. 1, Box 167 | |
| 3. NAME OF DECEASED
(Type or print)
Shirley Diane Thomas | | 4. DATE OF DEATH
Month 3 Day 25 Year 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10 Nov. 1966 |
| 9. AGE (In years lost birthday) yrs.
4 | | IF UNDER 1 YEAR
Months 4 Days 19 Hours 67 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Cheverly, Pr. Geo. Co. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Albert Leroy Johnson | | 14. MOTHER'S MAIDEN NAME
Bernice G. Thomas | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Bernice Thomas - Rt. 1-Box 167 | | Address
Brandywine Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Undetermined
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) SDII
DUE TO
(c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
John Kehoe M.D. | | 22. DATE SIGNED
3-26-67 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, or REMOVAL (Specify) | 23b. DATE THEREOF
3-28-67 | 23c. NAME OF CEMETERY OR CREMATORY
Church of God - Cemetery | 23d. LOCATION (City or Town) (County) (State)
Brandywine Pr. Geo. Md. |
| 24. FUNERAL DIRECTOR
Marshall Adams Aquasco, Md. | | 25a. REC'D BY REGISTRAR
DATE APR 6 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13140

33140

13140

33140

13140

33140

13140

33140

13140

33140

13140

33140

13140

33140

13140

33140

13140

33140

13140

33140

13140

33140

13140

33140

13140

33140

13140

33140

13140

33140

13140

33140

13140

33140

13140

33140

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04163

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04162

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | | | c. LENGTH OF STAY IN 1b
DOA | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George General Hospital | | | | d. STREET ADDRESS
12604 Kilbourne Lane | | | |
| 3. NAME OF DECEASED (Type or print)
First Edward Middle D. Last Thompson | | | | 4. DATE OF DEATH
Month 3 Day 7 Year 1967 | | | |
| 5. SEX
male | | 6. COLOR OR RACE
white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
28 March 1917 | |
| 9. AGE (In years lost birthday)
49 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY
Lee Fencing Co. | | 11. BIRTHPLACE (State or foreign country)
Virginia | |
| 13. FATHER'S NAME
Ernest R. Thompson | | | | 14. MOTHER'S MAIDEN NAME
Iola C. Connor | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
- | | 17. INFORMANT
Mrs. Dorothy Thompson (above address) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4200 IMMEDIATE CAUSE (a) Heart failure
DUE TO Arteriosclerotic heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) _____
(c) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH
minutes
unknown | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. _____ p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John Kehoe M.D. | | | | 22. DATE SIGNED
3-7-67 | | | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | | | Address (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
3/9/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Prospect Hill Cem. | | 23d. LOCATION (City or Town) (County) (State)
Front Royal, Va. | |
| 24. FUNERAL DIRECTOR Nalley's Funeral Home Inc. | | | | ADDRESS Mt. Rainier, Maryland | | REC'D BY REGISTRAR MAR 9 1967 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

04180

04180

James George's

James George's

John

John

John George's

John George's

John

John

John

John

John

John

John

John

John

John

John

John

John

John

John

John

John

John

John

John

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

74

VR A15 (4)
20 M 1/66

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|--|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| 05728 | | CERTIFICATE OF DEATH | |
| 05728 | | 05728 | |
| 1. PLACE OF DEATH
o. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beaver Heights | |
| c. LENGTH OF STAY IN 1b 1 day | | d. STREET ADDRESS 1413 52nd Ave. Apt. 302 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last | | 4. DATE OF DEATH Month Day Year | |
| 5. SEX Male | | 6. COLOR OR RACE Colored | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3-22-67 | |
| 9. AGE (In years lost birthday) yrs. 23 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11. BIRTHPLACE (County & State, or foreign country) Prince George's, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Francis Elwood Thornton, Sr. | | 14. MOTHER'S MAIDEN NAME Grace Lorraine Jackson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mother | | Address As above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
776X IMMEDIATE CAUSE (a) Pneumonia (3.2. Ponds)
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 3-22-67 , to 3-23-67 , that (I) (we) last saw the deceased alive on 3-23-67 and that death occurred at 4:50P M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE F. Kazemi | | 22b. DATE SIGNED 3/24/67 | |
| 22c. PHYSICIAN'S NAME (Type) Farizar Kazemi, M.D. | | 22d. ADDRESS Prince Georges General Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 23b. DATE THEREOF 4/8/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp | | 23d. LOCATION (City or Town) (County) (State) Cheverly PG Maryland | |
| 24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin., Cheverly, Maryland | | 25a. REC'D BY REGISTRAR APR 11 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

7-228158

05328

05328

05328

Prince George's General Hospital

Prince George's General Hospital

Prince George's General Hospital

Prince George's General Hospital

Prince George's General Hospital

Prince George's General Hospital

Prince George's General Hospital

Prince George's General Hospital

Prince George's General Hospital

Prince George's General Hospital

Prince George's General Hospital

Prince George's General Hospital

Prince George's General Hospital

Prince George's General Hospital

Prince George's General Hospital

05328

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04164

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04163

| | | | | | |
|---|-------------------------------|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE Maryland b. COUNTY Prince George's | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | c. LENGTH OF STAY IN IB DOA | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | | d. STREET ADDRESS 803 Karen Court | | |
| 3. NAME OF DECEASED (Type or print)
First Bernard Middle William Last Tracy | | | 4. DATE OF DEATH
Month 3 Day 16 Year 19 67 | | |
| 5. SEX Male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 19 Aug. 1930 | 9. AGE (In years lost birthday) 36 yrs. | 10. IF UNDER 1 YEAR
Months 3 Days 16 Hours 19 Min. 67 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Loan Officer | | 10b. KIND OF BUSINESS OR INDUSTRY Citizen's Bank | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Edward B. Tracy | | | |
| 14. MOTHER'S MAIDEN NAME Margaret Farley | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes 1952-1954 | | | |
| 16. SOCIAL SECURITY NO. 1952-1954 | | 17. INFORMANT Edward Tracy-Livittown, Pa. Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive subarachnoid and left internal capsular hemorrhage
DUE TO minutes
(b) And coronary artery occlusion, old and recent.
DUE TO Hypertensive arteriosclerotic cardio vascular disease
(c) unknown. | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE John Kehoe M.D. | | 22. DATE SIGNED 3-16-67 | | | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 3-20-67 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington Natl | |
| 23d. LOCATION (City or Town) Arlington Va | | (County) | | (State) | |
| 24. FUNERAL DIRECTOR De Witt Canadon | | ADDRESS Paul | | 25a. REC'D BY REGISTRAR MAR 27 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |

04163

04163

John George

John George

John George

John George

John George

John George

John George

John George

John George

John George

John George

John George

John George

John George

John George

John George

John George

John George

John George

John George

John George

John George

John George

John George

John George

John George

John George

John George

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04165

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04164

| | | | | | | | |
|--|---------------------------------------|---|--|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Riverdale | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Riverdale 16-1 | | | |
| c. LENGTH OF STAY IN 1b
DOA | | | | d. STREET ADDRESS
5514 Madison Street | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Chamber's Funeral Home | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Loretta Middle Doudiken Last Waddell | | | | 4. DATE OF DEATH
Month 3 Day 9 Year 19 67 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
23 April 1912 54 yrs. | | 9. AGE (In years last birthday)
54 yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Edward F. Doudiken | | | | 14. MOTHER'S MAIDEN NAME
Catherine Shipley | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Mr. Robert W. Waddell Address same address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Burns - total body
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
9160 | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Burned when bed caught fire. | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 12:10am 3-9- 19 67 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input checked="" type="checkbox"/>
at work at work x | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
home | | 20f. (City or town) (County) (State)
same as #2 | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John Kehoe M.D. | | | | 22. DATE SIGNED
3-9-67 | | | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
3/13/1967 | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR
Wm J. Fickner & Sons ADDRESS Baltimore, Md. North & Pa. | | | | 25a. REC'D BY REGISTRAR
MAR 13 1967 | | 25b. REGISTRAR'S SIGNATURE
J Charles Judge | |

04101

04101

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04166

CERTIFICATE OF DEATH

04165

| | | | |
|---|---------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George Co.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton Md.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hughesville Md.</u> 08-2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pineview Gardens Center</u> Health | | d. STREET ADDRESS <u>Stuart Lane</u> | |
| 3. NAME OF DECEASED (Type or print) <u>William Wade</u> | | 4. DATE OF DEATH <u>Mar. 5 1967</u> | |
| 5. SEX <u>7. Male</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-17-1985</u> |
| 9. AGE (In years last birthday) <u>81</u> yrs. | | IF UNDER 1 YEAR
Months <u>3</u> Days <u>5</u> Hours <u>19</u> Min. <u>67</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>maid</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Winnsboro S. Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>John Wikes</u> | | 14. MOTHER'S MAIDEN NAME <u>Phyllis Ellson</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <u>579-03-9592</u> | |
| 17. INFORMANT <u>Martin L. McDowell</u> | | Address <u>McChesville Md. Rt. 2</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>203X Cardiovascular Collapse</u>
DUE TO (b) <u>Neurostatic Carcinoma</u>
DUE TO (c) <u>Multiple Myeloma</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>3-5 days</u>
<u>2-3 months</u>
<u>5 months</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb 5</u> , 19 <u>67</u> , to <u>March 5</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>March 5</u> , 19 <u>67</u> , and that death occurred at <u>5:15</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Alfred R. Lapin</u> M.D. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN MD</u> | | 22d. ADDRESS <u>CLINTON, MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>3-8-67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cath. Ch. Cem. Bryantown Chas. Co. Md.</u> | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR <u>Martell Adams Aquasco, Md.</u> | | 25a. REC'D BY REGISTRAR <u>MAR 13 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | | | |

05125

33180

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04167 Items #10b & 15 Film #3286 3/15/67
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04166

| | | | | | |
|--|---|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | c. LENGTH OF STAY IN TB DOA | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | | d. STREET ADDRESS 5906 I Street | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last William Clarence Walton | | | 4. DATE OF DEATH
Month Day Year 3 6 19 67 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-12-1893 | 9. AGE (In years lost birthday) 74 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician | | 10b. KIND OF BUSINESS OR INDUSTRY Own Business | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Olin Scott Walton | | | 14. MOTHER'S MAIDEN NAME Sarah Silver | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) Unknown | | 16. SOCIAL SECURITY NO. 577-05-5657 | | 17. INFORMANT Address Mrs. Myrtle Virginia Walton - Item #2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure
4200 DUE TO Arteriosclerotic heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH
minutes
unknown |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE John Kehoe M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED 3-7-67 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 3/9/67 | 23c. NAME OF CEMETERY OR CREMATORY Cedarville Full Gospel | 23d. LOCATION (City or Town) Cedarville | (County) | (State) Md. |
| 24. FUNERAL DIRECTOR ADDRESS Ritchie Bros. Upper Marlboro, Md. | | | 25a. REC'D BY REGISTRAR MAR 8 1967 | 25b. REGISTRAR'S SIGNATURE John Kehoe | |

0110

0110

0110

0110

0110

0110

0110

0110

0110

0110

0110

0110

0110

0110

0110

0110

0110

0110

0110

0110

0110

0110

0110

0110

0110

0110

0110

0110

0110

0110

0110

0110

FOR STATE
HEALTH DEPT

04168

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04167

| | | | |
|---|----------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN IS
DOA | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Greenbelt | | d. STREET ADDRESS
Box 61 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George's Hospital | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Robert James Warnke | | 4. DATE OF DEATH
Month Day Year
March 11 19 67 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
2-14-26 |
| 9. AGE (In years last birthday)
41 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MACHINIST | | 10b. KIND OF BUSINESS OR INDUSTRY
MACHINIST | |
| 11. BIRTHPLACE (State or foreign country)
STATE OF NEW YORK | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
ERNEST W. WARNKE | | 14. MOTHER'S MAIDEN NAME
CATHALEEN POST | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
UNKNOWN | | 16. SOCIAL SECURITY NO.
069-24-9905 | |
| 17. INFORMANT
ELMSFORD, Address NEW YORK | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Delirium Tremens
307X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____ | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
John Kehoe, M.D. | | 22. DATE SIGNED
3-12-67 | |
| EXAMINER'S NAME (Type)
John Kehoe, M.D. | | 23. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (City or town) (County) (State)
Riverdale, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
3/15/1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
MT. CALVARY CEMETERY | | 23d. LOCATION (City or town) (County) (State)
GREENBURG, NEW YORK | |
| 24. FUNERAL DIRECTOR
HYSONG'S FUNERAL HOME | | 25. ADDRESS
WASH. D.C. 1300 N. ST., N.W. | |
| 25a. REC'D BY REGISTRAR
Charles Judge | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04163

04168

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

X

10-10-68

10-10-68

10

10-10-68

10-10-68

10-10-68

10-10-68

10

10-10-68

10

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

10-10-68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04169

CERTIFICATE OF DEATH

04168

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Pro George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Adelphi, Md. | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Paint Branch Nursing Home | | d. STREET ADDRESS
11128 Emack Road | |
| 3. NAME OF DECEASED (Type or print)
First Ethel Middle L Last Wells | | 4. DATE OF DEATH
Month March Day 2 , Year 1967 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan 18, 1895 |
| 9. AGE (In years and birthday)
72 yrs. | | 10. IF UNDER 1 YEAR
Months Days | 11. IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
own home | |
| 11. BIRTHPLACE (County & State, or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
Elliott | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Bernard L Wells | | Address
Beltsville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
332X IMMEDIATE CAUSE (a) Cerebral Thrombosis
DUE TO Generalized Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Diabetic Mellitus | | INTERVAL BETWEEN ONSET AND DEATH
5 hr | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 3/2 , 19 67 to 3/2 , 19 67 , that (I) (we) last saw the deceased alive on 3/2 , 19 67 , and that death occurred at 5P M, from causes and on the date stated above. | | 22a. SIGNATURE
W.K. Etienne
M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type)
W.K. Etienne | | 22b. DATE SIGNED
3/2/67 | |
| 22d. ADDRESS
College Park, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
March 6, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Ft Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Colmar Manor Pro Geo Md. | |
| 24. FUNERAL DIRECTOR
F. Gasch's Sons | | 25a. REC'D BY REGISTRAR
DATE MAR 6 1967 | |
| ADDRESS
Hyattsville, Md. | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

04168

LABORATORY DATA

04168

Handwritten: Chemical Analysis
of the substance

Handwritten: Blue solution

Handwritten: W. Etienne
3/2 01

Handwritten: College Park
3/2 3/2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1-67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04170

CERTIFICATE OF DEATH

04169

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Prince George MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital | | d. STREET ADDRESS 6107 Queens chapel Rd., | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last Ruel S. Wheeler | | 4. DATE OF DEATH Month 3-21 Day 19 Year 67 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-29-00 |
| 9. AGE (In years last birthday) 66 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) installer | | 10b. KIND OF BUSINESS OR INDUSTRY Retired phone company | |
| 11. BIRTHPLACE (County & State, or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Arthur Middleton Wheeler | | 14. MOTHER'S MAIDEN NAME Edna Mae Johnson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Daughter & medical Records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4500 CONGESTIVE HEART FAILURE
DUE TO (b) GEN. ARTERIOSCLEROSIS
DUE TO (c) UNKNOWN
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH 2 DAYS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) BRONCHIAL ASTHMA | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 2-29-1948, to 3-21-1967, that (I) (we) last saw the deceased alive on 3-20-1967, and that death occurred at 6:21 AM, from causes and on the date stated above. | | | |
| 22a. SIGNATURE C. J. Houmann | | 22b. DATE SIGNED 3-21-67 | |
| 22c. PHYSICIAN'S NAME (Type) C. J. Houmann, M.D. | | 22d. ADDRESS 4404 Queensbury Rd., Riverdale, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 3-24-67 | 23c. NAME OF CEMETERY OR CREMATORY Meadlands Mem | 23d. LOCATION (City or Town) (County) (State) Darsey Md |
| 24. FUNERAL DIRECTOR Dr. Witt Donaldson | | 25a. REC'D BY REGISTRAR MAR 28 1967 | |
| ADDRESS Laurel, Md | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

03110

07110

1001 8.5 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04171

04170

| | | | | | | | |
|---|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Riverdale, Maryland | | | c. LENGTH OF STAY IN 1b
7 days, 4hrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Laurel, Maryland | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Eugene Leland Memorial Hospital | | | | d. STREET ADDRESS
Rt. 1, Box 200, Laurel, Maryland | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Robert | | First A. Middle Whisner Last | | 4. DATE OF DEATH
Month March Day 8 Year 1967 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
7/15/1882 | | 9. AGE (In years lost birthday) yrs.
84 | IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Master Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY
Railroad | | 11. BIRTHPLACE (County & State, or foreign country)
Columbus Ohio | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
unknown | | | | 14. MOTHER'S MAIDEN NAME
unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
unknown | | 16. SOCIAL SECURITY NO.
398-05-5521 | | 17. INFORMANT
Records Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart Myocardial Infarction
DUE TO 4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Failure
DUE TO Compensated Heart Block
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <input type="checkbox"/> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1967 , 19 3/8 , to 3/8 , 19 67 , that (I) (we) last saw the deceased alive on 3/8 , 19 67 , and that death occurred at 3:00 M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Robert Wingfield | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
3/8/67 | |
| 22c. PHYSICIAN'S NAME (Type)
ROBERT WINGFIELD | | | | 22d. ADDRESS
Laurel Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
March 9, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodland Park | | 23d. LOCATION (City or Town) (County) (State)
Dayton Ohio | |
| 24. FUNERAL DIRECTOR
De Witt Canadian, Laurel Md | | | | 25a. REC'D BY REGISTRAR
MAR 13 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

07140

CERTIFICATE OF DEATH

07140

MAR 1 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and may be filed within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04172

CERTIFICATE OF DEATH

04171

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
o. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE MARYLAND b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Glenn Dale (rural) | | c. LENGTH OF STAY IN TB
5 months | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Glenn Dale Hospital | | d. STREET ADDRESS
4427 Quarles St., N.E. | |
| 3. NAME OF DECEASED (Type or print)
First Howard H. Middle White Last White | | 4. DATE OF DEATH
Month March Day 9 Year 1967 | |
| 5. SEX
M | 6. COLOR OR RACE
N | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7/15/34 |
| 9. AGE (In years last birthday)
32 yrs. | | 10. IF UNDER 1 YEAR
Months 00 Days 02 | 11. IF UNDER 24 HRS.
Hours 00 Min. 00 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Fence man | | 10b. KIND OF BUSINESS OR INDUSTRY
unknown | |
| 11. BIRTHPLACE (County & State, or foreign country)
Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
William White | | 14. MOTHER'S MAIDEN NAME
Cordelia White ? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
unknown | | 16. SOCIAL SECURITY NO.
225-34-0460 | |
| 17. INFORMANT
decadent | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute adrenal insufficiency
DUE TO (b) Acute hemorrhagic necrosis of the adrenals
DUE TO (c) Acute renal tubular necrosis: status post left upper lobectomy (2/27/67) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Pulmonary tuberculosis | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9/29/1966 to 3/9/1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3/9/1967 , and that death occurred at 7:00AM from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Moe Weiss | | 22b. DATE SIGNED
3/9/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Moe Weiss, M.D. | | 22d. ADDRESS
Glenn Dale Hospital, Glenn Dale, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
3-15-1967 | 23c. NAME OF CEMETERY OR CREMATORY
HARMONY | 23d. LOCATION (City or Town) (County) (State)
LANDOVER MARYLAND |
| 24. FUNERAL DIRECTOR
Tarvis Funeral Home | | 25a. REC'D BY REGISTRAR
14 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | 25c. DATE
14 1967 | |

1941

1941

Prince George

Washington, D. C.

3 months

Glenn Dale (trump)

4000 Charles St., N.W.

Glenn Dale Hospital

March 7, 41

White

Howard H.

30

7/15/41

EX

H

M

UNA

Washington, D. C.

Unknown

ence and

Corneille White 7

William White

deceased

321-34-0450

unknown

Reported by the subject

Reported by the subject

Reported by the subject

Reported by the subject

Reported by the subject

3/10/41

3/10/41

3/10/41

X

3/10/41

XX

3/10/41

Glenn Dale Hospital, Glenn Dale, Md.

Los Angeles, N.D.

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

51

52

53

54

55

56

57

58

59

60

61

62

63

64

65

66

67

68

69

70

71

72

73

74

75

76

77

78

79

80

81

82

83

84

85

86

87

88

89

90

91

92

93

94

95

96

97

98

99

100

101

102

103

104

105

106

107

108

109

110

111

112

113

114

115

116

117

118

119

120

121

122

123

124

125

126

127

128

129

130

131

132

133

134

135

136

137

138

139

140

141

142

143

144

145

146

147

148

149

150

151

152

153

154

155

156

157

158

159

160

161

162

163

164

165

166

167

168

169

170

171

172

173

174

175

176

177

178

179

180

181

182

183

184

185

186

187

188

189

190

191

192

193

194

195

196

197

198

199

200

201

202

203

204

205

206

207

208

209

210

211

212

213

214

215

216

217

218

219

220

221

222

223

224

225

226

227

228

229

230

231

232

233

234

235

236

237

238

239

240

241

242

243

244

245

246

247

248

249

250

251

252

253

254

255

256

257

258

259

260

261

262

263

264

265

266

267

268

269

270

271

272

273

274

275

276

277

278

279

280

281

282

283

284

285

286

287

288

289

290

291

292

293

294

295

296

297

298

299

300

301

302

303

304

305

306

307

308

309

310

311

312

313

314

315

316

317

318

319

320

321

322

323

324

325

326

327

328

329

330

331

332

333

334

335

336

337

338

339

340

341

342

343

344

345

346

347

348

349

350

351

352

353

354

355

356

357

358

359

360

361

362

363

364

365

366

367

368

369

370

371

372

373

374

375

376

377

378

379

380

381

382

383

384

385

386

387

388

389

390

391

392

393

394

395

396

397

398

399

400

401

402

403

404

405

406

407

408

409

410

411

412

413

414

415

416

417

418

419

420

421

422

423

424

425

426

427

428

429

430

431

432

433

434

435

436

437

438

439

440

441

442

443

444

445

446

447

448

449

450

451

452

453

454

455

456

457

458

459

460

461

462

463

464

465

466

467

468

469

470

471

472

473

474

475

476

477

478

479

480

481

482

483

484

485

486

487

488

489

490

491

492

493

494

495

496

497

498

499

500

501

502

503

504

505

506

507

508

509

510

511

512

513

514

515

516

517

518

519

520

521

522

523

524

525

526

527

528

529

530

531

532

533

534

535

536

537

538

539

540

541

542

543

544

545

546

547

548

549

550

551

552

553

554

555

556

557

558

559

560

561

562

563

564

565

566

567

568

569

570

571

572

573

574

575

576

577

578

579

580

581

582

583

584

585

586

587

588

589

590

591

592

593

594

595

596

597

598

599

600

601

602

603

604

605

606

607

608

609

610

611

612

613

614

615

616

617

618

619

620

621

622

623

624

625

626

627

628

629

630

631

632

633

634

635

636

637

638

639

640

641

642

643

644

645

646

647

648

649

650

651

652

653

654

655

656

657

658

659

660

661

662

663

664

665

666

667

668

669

670

671

672

673

674

675

676

677

678

679

680

681

682

683

684

685

686

687

688

689

690

691

692

693

694

695

696

697

698

699

700

701

702

703

704

705

706

707

708

709

710

711

712

713

714

715

716

717

718

719

720

721

722

723

724

725

726

727

728

729

730

731

732

733

734

735

736

737

738

739

740

741

742

743

744

745

746

747

748

749

750

751

752

753

754

755

756

757

758

759

760

761

762

763

764

765

766

767

768

769

770

771

772

773

774

775

776

777

778

779

780

781

782

783

784

785

786

787

788

789

790

791

792

793

794

795

796

797

798

799

800

801

802

803

804

805

806

807

808

809

810

811

812

813

814

815

816

817

818

819

820

821

822

823

824

825

826

827

828

829

830

831

832

833

834

835

836

837

838

839

840

841

842

843

844

845

846

847

848

849

850

851

852

853

854

855

856

857

858

859

860

861

862

863

864

865

866

867

868

869

870

871

872

873

874

875

876

877

878

879

880

881

882

883

884

885

886

887

888

889

890

891

892

893

894

895

896

897

898

899

900

901

902

903

904

905

906

907

908

909

910

911

912

913

914

915

916

917

918

919

920

921

922

923

924

925

926

927

928

929

930

931

932

933

934

935

936

937

938

939

940

941

942

943

944

945

946

947

948

949

950

951

952

953

954

955

956

957

958

959

960

961

962

963

964

965

966

967

968

969

970

971

972

973

974

975

976

977

978

979

980

981

982

983

984

985

986

987

988

989

990

991

992

993

994

995

996

997

998

999

1000

04173

CERTIFICATE OF DEATH

04173

1111 2nd Avenue

Three George County

William

John

March 1, 1900

John

John

Alaska

Honolulu

John Brown

John Brown

John Brown 1111 2nd Avenue

John Brown 1111 2nd Avenue

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #7 Film #G307 4/3/67 bc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04174

04173

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Indiana b. COUNTY
Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Salem 52.3 | |
| c. LENGTH OF STAY IN 1b
DOA | | d. STREET ADDRESS
Box #430 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George's General Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Edward Everett Williams | | 4. DATE OF DEATH
Month Day Year
3 26 1967 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12-19-10 |
| 9. AGE (In years last birthday)
56 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Manufacturer | | 10b. KIND OF BUSINESS OR INDUSTRY
Garments | |
| 11. BIRTHPLACE (State or foreign country)
Indiana | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Elmer T. Williams | | 14. MOTHER'S MAIDEN NAME
Bertha Morris | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Robert Williams | | Address
1935 Brook Drive Hillside Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart Failure
4200
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Arteriosclerotic Heart Disease
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH
10 years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
John Kehoe M.D. | | 22. DATE SIGNED
3-26-67 | |
| EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
Mar. 26, 1967 | 23c. NAME OF CEMETERY OR CREMATORY
Crown Hill | 23d. LOCATION (City or Town) (County) (State)
Salem, Ind. |
| 24. FUNERAL DIRECTOR
Robert E. Wilhelm 4308 Suitland Rd.
Suitland Md. | | 25a. REC'D BY REGISTRAR
MAR 30 1967 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

04113

04113



FOR STATE
HEALING DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04175

04174

| | | | |
|---|-------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hillcrest Heights | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Riverdale | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Parking lot of 3206 Curtis Drive | | d. STREET ADDRESS
6314 Kennedy Street | |
| 3. NAME OF DECEASED (Type or print)
First Huey Middle Kyle Last Wilson | | 4. DATE OF DEATH
Month 3 Day 1 Year 19 67 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5-9-1935 |
| 9. AGE (In years lost birthday) yrs. 31 | | 10. IF UNDER 1 YEAR Months Days Hours Min. 19 67 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
GUARD | | 10b. KIND OF BUSINESS OR INDUSTRY
NAT. SECURITY GAURD | |
| 11. BIRTHPLACE (State or foreign country)
TENNESSEE | | 12. CITIZEN OF WHAT COUNTRY?
U.S | |
| 13. FATHER'S NAME
CHARLES WILSON | | 14. MOTHER'S MAIDEN NAME
OLLIE B. PERKS | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
KOREAN YES KOREAN | | 16. SOCIAL SECURITY NO.
409 48 4383 | |
| 17. INFORMANT
KATHYLEEN WILSON | | Address SAME AS 2 ABCD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
983X
IMMEDIATE CAUSE (a) Asphyxia
DUE TO Aspiration of gastric contents
(b) Secondary to multiple rib fractures
DUE TO From trauma
(c) | | INTERVAL BETWEEN ONSET AND DEATH
minutes | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
ant. Vomited and aspirated in association with attack by assail- | |
| 20c. TIME OF INJURY Month, Day, Year
between 1:2:00am 3-1- 1967 | | 20d. INJURY OCCURRED
While <input checked="" type="checkbox"/> Not While <input type="checkbox"/>
of work <input checked="" type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Parking lot 3206 Curtis Dr., Hillcrest Hgts. | | 20f. (City or town) (County) (State)
Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
John Kehoe
EXAMINER'S NAME (Type) John Kehoe, M.D. | | 22. DATE SIGNED
3-2-67 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
6 MAR. 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
HAPPY VALLEY MEM PK | | 23d. LOCATION (City or town) (County) (State)
ELIZABETHTON TENN | |
| 24. FUNERAL DIRECTOR
W.W. CHAMBERS Co | | 25. ADDRESS
RIVERDALE, MD. | |
| 26. REG'D BY REGISTRAR
MAR 8 1967 | | 27. REGISTRAR'S SIGNATURE
Charles Judge | |

04175

04175

17-10-1967

17-10-1967

17-10-1967

17-10-1967

17-10-1967

17-10-1967

17-10-1967

17-10-1967

17-10-1967

17-10-1967

17-10-1967

17-10-1967

17-10-1967

17-10-1967

17-10-1967

17-10-1967

17-10-1967

17-10-1967

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04176

CERTIFICATE OF DEATH

04175

| | | | | | | | |
|--|--|---|---|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>D.C.</u> b. COUNTY <u>-</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hyattsville</u> | | | c. LENGTH OF STAY IN TB
<u>4 mo.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Washington</u> <u>47-3</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Hyattsville Nursing Home</u> | | | | | d. STREET ADDRESS
<u>612 Fern Place N.W.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>Bertha</u> <u>Blanche</u> <u>Wineberger</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>March</u> <u>5</u> <u>1967</u> | | | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>10/12/77</u> | | 9. AGE (In years lost birthday)
<u>89</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>-</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Washington D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Henry Yost, Sr.</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Caroline Brandt</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>579-60-1395</u> | | 17. INFORMANT
Address
<u>Daughter - 612 Fern Place N.W. Washington, D.C.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>uremic coma</u>
446X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>nephrosclerosis and bilateral pyelonephritis</u> 9 mo
DUE TO (c) <u>-</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>a series of cerebral vascular accidents</u> | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
<u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 15</u> , 1966, to <u>3/5</u> , 1967, that (I) (we) last saw the deceased alive on <u>3/4</u> , 1967, and that death occurred <u>at 4 M.</u> from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>D.B. Washington</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED
<u>3/5/67</u> | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>D.B. Washington MD</u> | | | | 22d. ADDRESS
<u>5802 Ridgefield Rd Bethesda 14 Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>3-7-1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Rock Creek Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Washington D.C.</u> | | | |
| 24. FUNERAL DIRECTOR
<u>JOSEPH SAUER'S SONS INC</u> | | | | 25a. REC'D BY REGISTRAR
<u>MAR 9 1967</u> | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02110

TESTIMONY OF DEAN

02110

1964-1965

1964-1965

1964-1965

1964-1965

FOR STATE
HEALTH DEPT.

04177

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04176

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland b. COUNTY
Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Forest Heights 1611 | |
| c. LENGTH OF STAY IN 1b
DOA | | d. STREET ADDRESS
127 Foxway Drive | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George General Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Foster Woods | | 4. DATE OF DEATH
Month Day Year
3 22 19 67 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
12-13-1895 |
| 9. AGE (In years last birthday)
71 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Attorney | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Md | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Court Foster Wood | | 14. MOTHER'S MAIDEN NAME
Unk | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Grace Wood. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure
4200 DUE TO Arteriosclerotic heart disease
over 10 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<i>John Kehoe</i>
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | 22. DATE SIGNED
3-22-67 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | 23b. DATE THEREOF
3.24.67 | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crametory | 23d. LOCATION (City or Town) (County) (State)
Washington D C |
| 24. FUNERAL DIRECTOR
Lee Funeral Home 300.4th st N E | | 25a. REC'D BY REGISTRAR
MAR 27 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04178

04178

Police Bureau

Police Bureau

Police Bureau

Police Bureau

Police Bureau

Police Bureau

Police Bureau

Police Bureau

Police Bureau

Police Bureau

Police Bureau

Police Bureau

Police Bureau

Police Bureau

Police Bureau

Police Bureau

Police Bureau

Police Bureau

Police Bureau

Police Bureau

Police Bureau

Police Bureau

Police Bureau

Police Bureau

Police Bureau

Police Bureau

Police Bureau

Police Bureau

Police Bureau

Police Bureau

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04178 CERTIFICATE OF DEATH 04177

| | | | |
|--|----------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH
a. CDUNTY <i>Prince Geo.</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <i>Maryland</i> b. CDUNTY <i>Pr. Geo.</i> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<i>Cherry</i> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<i>Suitland</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<i>Prince Geo. General</i> | | e. STREET ADDRESS
<i>4838 Eastern Lane</i> | |
| 3. NAME OF DECEASED (Type or print)
First <i>Philip</i> Middle <i>KEE</i> Last <i>WOOD</i> | | 4. DATE OF DEATH
Month <i>March</i> Day <i>18</i> Year <i>1967</i> | |
| 5. SEX
<i>Male</i> | 6. COLOR OR RACE
<i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>3/18/04</i> |
| 9. AGE (In years last birthday) <i>63</i> yrs. | | 10. IF UNDER 1 YEAR
Months <i>16</i> Days <i>1</i> Hours <i>1</i> Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Cab driver</i> | | 11b. KIND OF BUSINESS OR INDUSTRY
<i>Taxi</i> | |
| 12. BIRTHPLACE (County & State, or foreign country)
<i>Seat Pleasant, Md.</i> | | 13. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 14. FATHER'S NAME
<i>Elliott Wood</i> | | 15. MOTHER'S MAIDEN NAME
<i>Bertha Schultz</i> | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<i>no</i> | | 17. SOCIAL SECURITY NO.
<i>4201</i> | |
| 18. INFIRMANT
<i>Mrs. Philip Wood - 4838 Eastern Lane Suitland, Md.</i> | | Address | |
| 19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Arteriosclerotic Coronary</i>
<i>4201</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Heart Disease with Failure</i>
DUE TO (c) <i>7 years</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<i>Pulmonary Emphysema + Fibrosis</i> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
<input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <i>19</i> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>June 15, 1960</i> to <i>April 18, 1967</i> , that (I) (we) last saw the deceased alive on <i>April 16, 1967</i> , and that death occurred at <i>7:45</i> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>William Brainin</i> | | 22b. DATE SIGNED
<i>3/18/67</i> | |
| 22c. PHYSICIAN'S NAME (Type)
<i>WM BRAININ</i> | | 22d. ADDRESS
<i>6124 Central Ave, Capital Hill Md</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE THEREOF
<i>3/21/67</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<i>Addison Chapel Cemetery</i> | | 23d. LOCATION (City, town or county) (State)
<i>Prince Georges, Maryland</i> | |
| 24. FUNERAL DIRECTOR
<i>Robert E. Wilhelm Funeral Home</i> | | 25a. REC'D BY REGISTRAR
<i>MAR 20 1967</i> | |
| 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | 25c. ADDRESS
<i>4308 Suitland Rd. Suitland, Maryland</i> | |

00117

00117

[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]

[Faint, illegible handwritten text at the bottom of the page]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04179

04178

FOR STATE
HEALTH DEPT.

| | | | | | | | |
|---|----------------------------------|--|---|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | | c. LENGTH OF STAY IN TB
DOA | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hillside 16-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George General Hospital | | | | d. STREET ADDRESS
5803 M. Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Roger Middle S. Last Wood | | | | 4. DATE OF DEATH
Month 3 Day 6 Year 1967 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
22 Oct. 1902 | | 9. AGE (In years last birthday)
64 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY
Giant Food Stores | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John E. Wood | | | | 14. MOTHER'S MAIDEN NAME
Gertrude E. Schultz | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Pearl M. Wood Address 5803 M St Hillside Md | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lacerations of brain
9115 DUE TO Multiple fractures of skull
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Arm of fork lift truck fell on head. | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 11:00pm 3-6-1967 | | 20d. INJURY OCCURRED
While <input checked="" type="checkbox"/> Not While <input type="checkbox"/>
at work <input checked="" type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
6900 Sheriff Rd., Landover, Md. | | 20f. (City or town) (County) (State)
P.G. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
John Kehoe, M.D. | | EXAMINER'S NAME (Type) John Kehoe, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22. DATE SIGNED
3-7-67 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
3-9-1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Addison Chapel Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Seat Pleasant Maryland | |
| 24. FUNERAL DIRECTOR Wilhelm Funeral Home ADDRESS
4308 Suitland Road Suitland Maryland | | | | 25a. REC'D BY REGISTRAR
MAR 10 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04178

04178

Office General

Office General

Office General

Office General

Office General

Office General

Office General

Office General

Office General

Office General

Office General

Office General

Office General

Office General

Office General

Office General

Office General

Office General

Office General

Office General

Office General

Office General

Office General

Office General

Office General

Office General

Office General

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04180

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04179

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant | |
| c. LENGTH OF STAY IN IB DOA | | d. STREET ADDRESS 6401 Greig Street | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last Francis DeSalles Woods | | 4. DATE OF DEATH
Month Day Year 3 30 19 67 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 26 July 1925 |
| 9. AGE (In years lost birthday) 41 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wash. Sanitary Comm. | | 10b. KIND OF BUSINESS OR INDUSTRY Pr. Geo. Cty. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Woods | | 14. MOTHER'S MAIDEN NAME Marie Canty | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) WW 11 43 to 46 | | 16. SOCIAL SECURITY NO. 220-16-5787 | |
| 17. INFORMANT Betty Louise Woods | | Address 6401 Greig Street - Seat Pleasant, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized peritonites
5411 DUE TO Perforation of duodenal ulcer
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Recurrent duodenal ulcer
DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH
hours
hours
over 5 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe M.D. | | 22. DATE SIGNED 3-31-67 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF 4/3/67 | 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. | 23d. LOCATION (City or Town) (County) (State) Arlington, Virginia |
| 24. FUNERAL DIRECTOR Robert L. Murphy | | 25a. REC'D BY REGISTRAR APR 5 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

05158

92210

1025 1026

• 30 •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Lanham</u> | | c. LENGTH OF STAY IN 1b
<u>Bowie</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Magnolia Gardens Nursing Home</u> | | d. STREET ADDRESS
<u>8627 Park Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>James</u> First Middle Last | | 4. DATE OF DEATH <u>March 30</u> 19 <u>67</u> Month Day Year | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Mar. 20, 1880</u> 9. AGE (In years last birthday) <u>87</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Ret. U.S. Government Farm</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>U.S. Government</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Samuel F. Woods</u> | | 14. MOTHER'S MAIDEN NAME
<u>Unk.</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>William C. Woods</u> | | 8605 <u>Park Ave</u> <u>Bowie, Md</u> Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>central thrombosis</u>
332X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 day</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m.
<u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 13</u> , 19 <u>67</u> , to <u>3/30/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/30</u> 19 <u>67</u> , and that death occurred at <u>12:45 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Leon L. Levy</u> | | 22b. DATE SIGNED
<u>3/30/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Leon L. Levy</u> | | 22d. ADDRESS
<u>8605 Park Ave</u> | |
| 23a. BURIAL, CREMATION, or other disposition (Specify) | 23b. DATE THEREOF
<u>4/3/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Ft. Lincoln</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Colmar Manor P.G. Md.</u> |
| 24. FUNERAL DIRECTOR:
<u>Sachs's Funeral Home</u> | | 25a. REC'D BY REGISTRAR
<u>APR 3 1967</u> | |
| ADDRESS
<u>Hyattsville, Md</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

08150

1612